Section 1: Needs Assessment and Identification of the State's Targeted At-Risk Communities

Targeted As-Risk Communities and their Characteristics

Utah will target Salt Lake, Uintah, Weber, Washington, and Carbon County to expand home visiting services under the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting (MIECHV) program in Year 2. These counties were selected through a prioritization process that included several factors. The degree of risk in each county was used as the first level of prioritization. Risk was determined through a statewide needs assessment, ranking counties according to the number of data points that exceeded the state average. Other factors such as the presence of an existing evidence-based home visiting program, agency capacity, community readiness, and political will further aided in the final prioritization and selection process.

Salt Lake County is the most populous county in the state with the largest urban area. Almost 40% of the state population lives in this county. Population density is 1,666 per square mile. According to the 2009 American Community Survey (ACS) data, 29% of county residents are under 18 years of age; 9.2% are under five years of age. Eight percent (8%) of residents live at or below the federal poverty level; 13% of those in poverty are children under the age of eighteen. Department of Health (DOH) data collected in 2010 indicate that there were over 19,000 births in the county with 28% of those births being covered by Medicaid. Eight percent (8%) of births were to adolescent girls, ages 15-19, accounting for a teen birth rate of 37 vs. 33.94 statewide[1]. The table below illustrates the key variables that contribute to a high level of risk for Salt Lake County.

Table 1

2007-2009	Infant mortality (infant deaths/per 1000 births	Preterm births	Low birth-weight Births	Prenatal care in the first trimester
Salt Lake County	5.39	9.82%	7.45%	69%
State	4.95	9.65%	6.83%	76%

The OHV needs assessment also revealed an alarming increase in the number of births to Hispanic teens. This was evidenced when the birthrates were examined based on small area analysis. For example, in Salt Lake City, neighborhoods such as Rose Park and Glendale have a large Hispanic population and high percentages of families in poverty. Both neighborhoods have adolescent birth rates that are more than double the county, and almost triple the state rate, ranging, respectively, between 79 and 99. In addition, prenatal care in the first trimester is often not sought. According to DOH Vital Records Office in 2006-2008 only 65% of women received prenatal care early in their pregnancy; in Glendale the percentage was approximately 58%. Within Salt Lake County several cities have been identified as areas of high risk according to the data collected from the OHV needs assessment. Table 2 illustrates the key variables that contribute to a high level of risk in these cities.

[1] Utah's Indicator-Based Information System (IBIS). Adolescent Births, Girls Age 15-19, 2009. Teen birth rate measures the number of births to women 15-19 years of age per 1,000 women in that age group.

Table 2

City	Adolescent birth rate 2006-2008	Prenatal care in the first trimester	Families in poverty 2009	Single mothers in poverty 2009	Low birth-weight
Midvale	62.5	69.4%	16.9%	37.4%	8.1%
South Salt Lake	79.6	69%	20.6%	47%	8.2%
West Valley	83.5	66%	11%	24%	9.1%

Community Strengths

While the needs are great in Salt Lake County, the county also demonstrates much strength, such as a 211 telephone-based Info Bank that offers information about all the services available in Salt Lake County. The county government offers services to families such as parenting classes, after school programs, youth groups and counseling. There is a Family Support Center with three locations in the valley that provide crisis nursery care, in home parenting support, parenting classes and family counseling. The Indian Walk-In Center provides support for Native Americans. The Refugee and Immigrant Center provides culturally sensitive and language specific social services that include employment services, advocacy and education. Salt Lake County also benefits from a strong welfare system provided by various religious groups.

Uintah County is a rural county located in the northeast area of the state bordering Colorado to the east. It has a population density of 6 people per square mile. Historically, Uintah County's economy has been based on farming and ranching, but now relies heavily on extraction of oil and gas. The extraction industry has brought a positive change to the area by raising the personal income of residents but it has also brought with it social problems related to an influx of money, outsiders and limited entertainment opportunities contributing to juvenile crime, teen pregnancy, and high rates of child abuse. Rural communities such as Uintah County offer limited employment opportunities for young people. The lucrative nature of the oil and gas industry has led to high number of adolescents who drop out of high school to take jobs in the industry. According to 2008 data, the percent of high school drop-outs was more than triple the state average at seven percent (7%). According to DOH data for 2006-2008 the teen birth rate was 60 per 1,000 adolescent girls ages 15-19, almost double the state rate. Uintah County's child maltreatment rate in 2008 was almost 34 per 1,000 vs. the state rate of 14.5. More than 10 % of Uintah County's population lives in poverty. The juvenile crime rate in Uintah County is almost double the state rate (see below). The table below illustrates the key variables that contribute to a high level of risk for Uintah County.

Table 3

	Infant Mortality 2007-2009	Preterm births 2007-2009	Low Birth-weight 2007-2009	Juvenile Crime 2009
Uintah County	6.06	11.66 %	8.47%	6024
State	4.95	9.65 %	6.83%	3483

Community Strengths

Uintah County has a Children's Justice Center that was started in 1999 that connects Division of Family Services, Law Enforcement and others involved in abuse situations. The school district supports a limited amount of preschool for 3-4 year olds. This is a fee service program but does provide services to children with delays. There is an existing Parents as Teachers program with one home visitor. In addition, the Northeastern Counseling Center convenes monthly meetings

that include multiple state and community agencies from the area to share information about service provision and availability. There is a strong collaborative relationship between service providers due the rural nature of the area. In addition, the lucrative nature of oil and gas extraction, while it has brought some social problems, has brought a steady stream of income to the area that is otherwise without much local industry.

Weber County, the third at-risk community of focus, is situated between the Wasatch Mountains on the east and the Great Salt Lake on the west, 35 miles north of Salt Lake City. It is the fourth most populous county in Utah. The county occupies 662 square miles and is composed of mixed urban-suburban/agricultural lands. Weber County's population has increased 18% since 2000 with children less than five years of age representing almost 10% of the population. Approximately 11% of the population lives at or below the poverty level. There has been a large increase in the number of families who are Spanish speaking only; 16% of the population is identified as Hispanic according to the 2009 American Community Survey data. Weber County's child maltreatment rate in 2009 was 22 per 1,000 vs. 14.5 for Utah as a whole. Table 4 illustrates the key variables that contribute to a high level of risk for families in Weber County.

Table 4

	Infant Mortality 2007-2009	Adolescent Birth Rate[2] 2007-2009	Prenatal care in the first trimester 2007-2009	Preterm births 2007-2009	Low birth-weight 2007-2009	High School drop-out 2008
Weber County	5.56	50.7	71%	10.77 %	7.37 %	5%
State	4.95	33.35	76%	9.65 %	6.83 %	2.%

Ogden is the largest city in Weber County and the 6th largest city in Utah. It has the unfortunate distinction of being an enterprise zone.[3] This designation is due to the numerous community risk factors such as poverty, crime and academic failure. The city of Ogden has a population of approximately 80,000. The need in this area is extensive. The OHV statewide needs assessment indicates that more than eight percent (8%) of children that reside in Ogden live in poverty. The city has an adolescent birth rate of 80.5 per 1,000 vs. 50.7 for the county; more than 13% of children live with a single parent, and only 11% of the city's population has a bachelor's degree. Almost 70% of the city's student population receives free or reduced lunch compared to the state average of 32%. Forty-four percent (44%) of students are English as Second Language learners. Language constraints can hinder educational progress. According to the biannual Utah Student Health and Risk Prevention (SHARP) survey[4], 29% of Ogden 6th graders have more than seven risk factors which are significantly higher than the state average. Forty-one percent of students reported poor family management (i.e. how families work and communicate together). Thirty-nine percent reported

[2] Utah's Indicator-Based Information System (IBIS). Adolescent Births, Girls Age 15-19, 2009. Teen birth rate measures the number of births to women 15-19 years of age per 1,000 women in that age group.
[3] Enterprise Zone is an impoverished area in which incentives such as tax concessions are offered to encourage investment and provide jobs for residents.
[4] The Student Health and Risk Prevention survey administered to students in 6,8,10 and 12 grades to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict these adolescent problem behaviors.

family conflict, and 36% reported a family history of anti-social behavior. According to the Division of Child and Family Service's data, Weber County had a child maltreatment rate of 22 per 1,000 vs. 14 statewide. In 2007, there were over 3,000 victims of alleged abuse; 887 resulted in supported CPS cases involving 1,481 children who were victims of abuse. Thirty percent of these supported cases also involved domestic violence.

Community Strengths

A major strength that was identified for Weber County was the presence of many organizations available to help families, especially those with issues related to child abuse and neglect. The Family Support Center provides crisis and respite care for children up to age 11. In addition they provide parenting support through a 12 week Basic Survival Skills class for parents with children 0-12. They have a limited capacity to provide in home services to families with children birth through five years old. These resources are available for the growing population of Spanish speakers. The Ogden Community Action Partnership (OWCAP) provides Head Start to over 700 children every year. OWCAP also provides employment assistance, low-income housing, and classes for families involved in Head Start. Your Community Connection YCC of Ogden is a non-profit community based organization that assists victims of domestic violence, rape and economic hardships by providing shelter, food and clothing to women. They also offer classes for the children of the women they serve. In addition to these resources there are several faith based organizations that support families with supplemental food assistance. Weber County also has a "Healthy Moms" coalition. It is coalition of community partners that was created for the purpose of serving Healthy Families Utah as a community partner for referrals, and as an advisory board. The original members were funders, community partners and referral sources such as St. Benedict's Foundation, Intermountain Healthcare, McKay Dee Hospital, Ogden Regional Medical Center, and Mid-town Community Health Center. The coalition has since expanded from these entities into a larger community resource composed of representatives from various agencies in Weber County.

Washington County is a rural county located in the southwest corner of Utah and is bordered by Nevada on the west and Arizona to the south. As identified in the statewide needs assessment, residents of Washington County experience high rates of poverty, 14.7 percent vs. 11% statewide. According to the most recent census data, Washington County had the highest percent of children in the state living in poverty at 18.8%.

The Hispanic population in Washington County grew by 121% from 2004-2007. Although Hispanics are less than 7% of the general population, they are 12% of the student enrollment in the Washington County School District. The 2009 Early Head Start Needs Assessment in Washington County, noted that 55% of families served in Early Head Start were Hispanic, nearly all of them immigrants who had been in the United States for less than 5 years. Table 5 lists additional risk factors present in Washington County.

Table 5

	Percent receiving prenatal care in the first trimester 2007-2009	Adolescent Birth Rate 2007-2009	Child Maltreatment Rate 2009

Washington County	65%	36.36	20.6
State	76%	33.35	14.5

While every county and city in Utah has been impacted by the unrelenting recession, Washington County was particularly hard hit. One in 87 homes in Washington County is in foreclosure - the highest rate in Utah. Food stamp use jumped 55% in Washington County from January 2008 to January 2009 - the highest percentage gain in the state. A number of individuals living in small rural towns on the Nevada border were employed through Nevada's gambling industry. According to the Head Start Needs Assessment casino revenues are down 21% and 500 people in Utah lost casino related jobs at the close of 2009. Ninety-one percent of students in area school districts receive free or reduced lunch.

Additionally, the cities of Hilldale and Colorado City, locally referred to as the Twin Cities, are in Washington County. Almost the entire population of these two towns practice polygamy and are part of the Fundamentalist Church of Jesus Christ of Latter Day Saints. The average household size is 7.5 and many homes have six preschool age children at home. Poverty is rampant with annual per capita income at approximately $4,782 a year with more than 50% of the towns' residents living at half the poverty level. Estimates on the rate of infants and toddlers who are up-to-date in their immunizations by age 3 are less than 30%. Currently, twenty-five percent of children attending the local Early Head Start program are from these two towns.

Community Strengths
The biggest strength in Washington County is the collaboration and referral system that exists among programs. United Way hosts a telephone – based 211 calling system where the public can call 211 and be directed to the appropriate agency. The Early Learning Center hosts a resource document listing all the resources in the county on their website.

Services for women and children are available through several agencies. The Learning Center (TLC) serves pregnant women, infants and toddlers. They provide family support services trough two programs: Early Intervention, serving families of children birth to three years of age who are showing any kind of development delay and Early Head Start, for low income pregnant women and families of children birth to three. Family Support Center of Washington County provides crisis nursery, respite care, foster respite care, parenting education, safe visit exchange and supplemental care for families. Kid Space Extended Care programs are on 22 school campuses in the Washington Elementary School District. Kid Space is a before and after school program that provides high quality, school age care while supplementing learning. For over 15 years the DOVE Center has been providing safe, caring and confidential shelter, advocacy and support for victims of domestic violence and sexual assault. Another community strength is the programs' ability to hire and maintain highly qualified and bilingual staff.

Carbon County is 1,476 square miles and is located in central Utah. The area first became developed during the early 1880s when the Denver and Rio Grande Western Railroad, seeking a route from Denver to Salt Lake City, discovered and opened up the vast coal lands of the area. Coal mining became the major catalyst for development in the county. Today, coal mining continues to play a vital role in the county's economic and social development. Carbon County has a population density of 14 residents per square mile. The vast majority of the population lives in the

communities of Price, Helper, Wellington, East Carbon, and Sunnyside. Eight percent of the population of the county is under 5 years of age. While the majority of Carbon County residents are White, 12.4% are of Hispanic origin and 7% speak Spanish at home. Thirteen percent of Carbon County residents live in poverty and 7% live at or below 50% of federal poverty; 16% of children live in poverty. Table 6 lists risk factors of greatest concern in Carbon County.

Table 6

	Teen Birth Rate 2007-2009	Child Maltreatment Rate 2009	Percent of Premature Births 2007-2009	Percent of Low Birth-weight infants 2007-2009
Carbon County	45.77	62	14%	8.9%
State	33.35	14.5	9.7%	7.4%

Community Strengths
Community strengths identified by Carbon County are their ability to band together in a crisis, a strong sense of community in rural areas (e.g., community gardens), availability of resources to get needs met (public and private individuals), and recreational opportunities.

Despite the geographic and demographic difference of the targeted communities, all three counties identified the following of greatest need for families and participants in the implementing agencies:

- Secure housing
- Access to health care providers that accept Medicaid and CHIP
- Access to educational opportunities
- Social support networks
- Employment

Existing Home Visiting Services and Participant Characteristics
All five counties identified for MIECHV funding have at least one existing evidence-based home visiting program. The following paragraphs describe each of those programs by county. All programs are quite small and serve only a small percentage of their target population and all have waiting lists.

Salt Lake County
Salt Lake County now boasts three evidence-based home visiting programs that include three different models: NFP, PAT (PAT), and Early Head Start (EHS).

NFP served approximately 100 families, less than 10% of eligible mothers. Of the NFP participants 24% had limited English proficiency; more than 50% were under the age of 19; 55% were White and 37% were Hispanic; and 47% had not completed high school. Family median income was $13,500.

In Salt Lake County, Utah PAT (UPAT) served 59 families in 2010. Spanish speaking families comprised 65% of participant families; 80% were low income; and 75% lived in Title I school boundaries.

Two EHS Programs operate in Salt Lake County. The Salt Lake Community Action Head Start Program serves 12 families in its home-based program and 62 in its center-based program. The

Community Action home-based program is a new program started with receipt of federal stimulus funds in 2010. DDI Vantage EHS program serves 96 families in its home-based program and 52 in its center-based program. Of the program participants 45% were single parents, 80% were white, 55% identified as Hispanic; 43% had less than a high school education; and 42% spoke Spanish at home.

Uintah County
Uintah County has one evidence-based program, PAT. The program serves 40 families served by 1.5 FTEs. According to the last annual report, 46% of families were White, 50% were Hispanic, and 3.4% were Native American. Two percent of the families served entered the program prenatally; approximately 40% of the children in the program are under the age of two.

Weber County
Weber County has two home visiting programs**.** Prevent Child Abuse Utah is the host agency for the HFA home visiting program. HFA is funded for 45 slots. The most recent report from the Weber HFA program indicates that 63% of its participants are Hispanic/Latino, 21% White and 11% Black; 19% are mothers under the age of 18 and 39% have limited English proficiency. The median income of participants is $12,176.

The Ogden Family Support Center in Weber County provides crisis and respite nursery services but also provides parenting classes and a short-term home visiting program using the Bavolek curriculum. (www.nurturingparenting.com) The Family Support Center's home visiting program typically serves families referred by DCFS. HFA refers ineligible families to the Family Support Center; however the Family Support Center's programs are at capacity and carry waiting lists. The Family Support Center's home visiting program served 170 families in 2010.

Washington County
Washington County has only one evidence-based home visiting program, Early Head Start. Approximately 47% of participants are Hispanic and 3% are Native American. Forty-seven percent speak only Spanish at home; 81% are at or below 100% of the federal poverty guidelines; and 14 % are homeless. The program serves 160 families with 200 families on the waiting list for services.

Carbon County
Carbon County has only one Early Head Start Program that is funded to serve 60 pregnant women and children. Sixteen percent of families describe themselves as multi-racial; 26% are single-parent families; 100% report speaking English at home and 83% live below federal poverty guidelines.

Existing Mechanisms for Screening, Identifying, and Referring Families
Salt Lake County is the only community that has more than one evidence-based home visiting program yet no coordinated mechanisms for identifying and referring families to any of the programs has been established. Existing mechanisms in place are model and agency specific with frameworks for screening identifying and referring families guided by requirements of the national home visiting models. To address this gap in the "system" of home visiting, the OHV has been working with Salt Lake County to establish a coordinated referral and screening system. Recently, the OHV facilitated a meeting between the local NFP, EHS, PAT programs and the Family Support Center, the Head Start State Collaboration Director and the Community Based Child Abuse Prevention (CBCAP) grants administrator. The purpose of the meeting was to discuss how to

improve coordination and collaboration among programs focusing on existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community. This meeting was the first meeting of many to plan for community collaboration of the delivery of services in Salt Lake County. The OHV anticipates convening a second meeting in November 2011 and the group will decide how frequently they will continue to meet. Additional partners will be included in the future, such as WIC and the Indian Walk-in Center. While the state OHV will facilitate the process, the mechanisms for coordination will be developed by the community agencies and their partners. The OHV will work with all funded communities to facilitate improvement in their coordination with other service providers. A plan for this will be developed by the end of 2011.

Salt Lake's NFP receives referrals for eligible families through a variety of referral sources. Most frequently families are referred to the program from pregnancy test centers, the WIC program and community health clinics although some families are referred from a range of other sources as well. NFP has consistently worked to maintain relationships with its community referral sources which have allowed the NFP to ramp up to full caseload very quickly, surpassing the implementation recommendations set by the NFP National Service Office (NSO). NFP does not have a formal screening process for enrolling families; however eligible participants must be a first-time pregnant woman under 150% of the federal poverty level and must be enrolled no later than her 28th week of pregnancy.

Typically, the Salt Lake PAT program receives referrals from DCFS, school districts, its website, University of Utah Medical Center, Midvale Family Support Center, and Facebook. Recently, PAT negotiated an agreement with NFP to coordinate their referral process so that NFP will refer all mothers on their waiting list who will likely "age out", meaning they will pass their 28th week of pregnancy before an available NFP slot will become available. PAT is also in the process of developing relationships with new referral sources so that they can target pregnant women, especially pregnant teens.

Uintah County's PAT program receives referrals from doctor's offices, Division of Child and Family Services, Northeastern Counseling Center, WIC, Tri-County Health Department and Uintah Specialized Preschool Program. In anticipation of program expansion through the MIECHVP, the program supervisor has met with OB/GYN physicians who indicate that there are many pregnant women who could be referred to PAT if there was expanded capacity to serve families. This PAT program employs two home visitors and serves approximately 40 families.

Weber County's HFA program works closely with McKay Dee Hospital, Ogden Regional Clinic and the Midtown Community Health Clinic to identify potential families for the program. HFA developed MOUs with these referral sources that they have maintained throughout the three years they have been operating in Weber County. Additional referrals come from Ogden High School, WIC and the Weber-Morgan Health Department. Once families are referred to HFA, an assessment worker administers the Kempe Family Stress Inventory which is a standardized assessment tool to systematically identify families who are most in need of services. Essentially, the Kempe assesses parents' risk for child maltreatment and/or care-giving difficulties. Families are typically selected for being at risk if at least one of the parents is scored as high risk. Ineligible families are provided community referral sources and invited to participate in the monthly family socialization groups

provided by the program. Currently, no coordinated mechanism for screening, identifying, and referring families and children to home visiting programs exists at the state or local level for entry into an early childhood program, including a home visiting program.

The Washington County Early Head Start Program has a strong interagency agreement with Southwest Center Behavioral Health. These two programs co-visit families and provide parent and staff training. The EHS program also refers parents with substance abuse problems, including those who wish to quit using tobacco, to Southwest Center. For participants who enter the program prenatally, EHS has developed an interagency agreement with the community health center that provides the prenatal care and delivery for the mothers without insurance for $240. Additionally EHS has developed relationships with volunteer mental health providers for those with no insurance, with the local state college to provide dental care at no cost. In Washington County the EHS and Part C Early Intervention program are in the same agency and the same facility. Every child on the EHS waiting list receives an Ages and Stages Questionnaire (ASQ) so they can be screened to see if they are eligible for Early Intervention services.

Carbon County has a strong collaborative relationship with the County Part C Early Intervention program and the EHS director participated on the local Interagency Coordinating Council (ICC). Identified partners include the Department of Workforce Services, Vocational Rehab, Child Care Resource & Referral, local School Districts, Division of Child and Family Services, local health departments, the Children's Justice Center and Four Corners Behavioral Health. Rural Utah Child Development Center, which houses the EHS program, has written policies for referral of clients.

Through its application and RFP process, the OHV asks respondents to describe mechanisms in place for screening, identifying and referring families and children to existing program, and provide an inventory of referral resources currently available or needed in the future to support families. A plan for improved coordination among programs and resources in the community will be required.

Mechanism for referrals from the SLC Indian Walk-in Center and the Uintah Indian Health Service.

OHV staff is scheduled to meet with the director of the SLC Indian Walk-in Center on October 3, 2011 to learn about the organization and the services they offer as well as to discuss Utah's home visiting program and how we can engage the families they work with and integrate the Native American population into early childhood services. The OHV will meet with a representative from the Uintah Indian Health Service and with Melissa Zito, Indian Health Services liaison by the end of October. These various meetings will help establish a working relationship that will help the OHV identify exiting needs, explore possible linkages and processes of working together, and begin to establish referral and collaboration mechanisms which will enhance the opportunities to build the capacity of these local programs and services.

Utah is an international refuges resettlement state although the majority of families are resettled to the cities within Salt Lake County. Refugees receive services from the International Rescue Committee and Catholic Community Services for the first 6 months after their arrival. After the point, the Asian Association of Utah, a refugee and immigrant center, provides needed services to refugee families. The OHV met with the director of the Utah Asian Association on September 23, 2011 to learn more about the organization, the services they offer. As with the Indian Walk-in Center, the Uintah Health Service

and other organizations that work with the Native American population, the OHV will partner with these organizations to understand how we can collaborate to better meet the needs of families in these vulnerable populations.

In Salt Lake and Uintah counties, the OHV will facilitate the local home visiting programs in their outreach efforts to the Indian Walk-in Center and Indian Health Services to educate them about the home visiting program, develop a referral mechanism for identifying eligible families, and identifying other ways of collaboration. OHV staff is in the process of organizing meeting with the aforementioned programs and the home visiting programs in these two counties. The OHV has spoken with the home visiting supervisors about expanding their services to the Native American community and they were very responsive.

In addition, the OHV will invite personnel from the Indian Walk-in Center and Indian Health Services to participate in the Office of Home Visiting Advisory Committee. Engaging these groups will provide an opportunity to share information about the services they offer and the population they serve, as well as the providing some perspective on the significant needs that exist within these communities. Representatives from both of these organizations will be invited to participate regularly on the OHV Advisory Committee;

Local and State Capacity to Integrate the Proposed Home Visiting Services into an Early Childhood System

A challenge for Utah is the limited capacity of an early childhood system at the state and local levels. While early childhood leaders recognize the importance of a systems approach to improve service delivery and program accountability there is limited political support for the formalization of such a system and limited funding opportunities for programs that target early childhood development and family support.

Until recently, the Head Start State Collaboration Office (HSSCO) provided grants to communities to establish early childhood councils; however state general funding was cut during the 2011 Utah legislative session. In a few counties the councils have been able to build strong and active coalitions while others have had a more difficult time maintaining cohesion. These early childhood councils could act as a hub for convening community partners for planning, decision making, and capacity building for system development. As funding and capacity allow, the OHV will support local communities, beginning with those funded through the MIECHVP, to develop and improve coordination of home visiting into early childhood systems. Home visiting programs funded by this grant will be encouraged to participate in their local early childhood council to increase knowledge of home visiting in the community and to develop partnerships across other service systems to enhance cross-collaboration. The intention would be to use this opportunity to reinvigorate inactive councils and ensure that home visiting is represented in community planning around early childhood services. As the coalitions strengthen, they will be able to identify needs, guide planning and decision making, and build partnerships, thus building a supportive early childhood infrastructure.

The work of the OHV is guided by its Steering Committee and shared responsibility for the development of Utah's state home visiting plan. The OHV Steering Committee acts as an advisory body to the OHV providing strategic decision making, assists interagency coordination and will

provide leadership on policy development for the home visiting program. This committee will continue to support OHV and Utah's home visiting programs and new members will be added as needed. The Committee will meet monthly for the next year providing strong oversight to the MIECHV implementation activities. Committee membership includes:

Nan Streeter	Department of Health, Division of Family Health and Preparedness and Maternal and Child Health Deputy Director
Harper Randall	Department of Health, Medical Director, Children with Special Health Care Needs
Teresa Whiting	Department of Health, Director, Bureau of Child Development
Susan Ord	Department of Health, Manager, Baby Watch Early Intervention Program
Rudy Anderson	Department of Health, Head Start State Collaboration Director
Lynette Rasmussen	Department of Workforce Services, Office of Child Care and CCDF Administrator
Heidi Valdez	Department of Human Services, Division of Child and Family Services, CBCAP Administrator
Craig Povey	Department of Human Services, Division of Mental Health and Substance Abuse
Rodney Hopkins	University of Utah, Social Research Institute
Mark Innocenti	Utah State University, Early Intervention Research Institute
Robyn Lipkowitz	Department of Health, Office of Home Visiting

Section 2: Home Visiting Program's Goals and Objectives

Goals and Objectives of the State Home Visiting Program

Utah envisions a future where communities can provide a continuum of services, including early childhood services, which support families and children, with home visiting being an integral piece of this service system. This includes promoting evidence-based home visiting in Utah that improves the health and developmental outcomes of young children; ensures that children live in safe and nurturing environments; and strengthens parent-child relationships.

The OHV was established in 2008 through funding from the federal Department of Health and Human Services, Administration for Children and Families, *Supporting Evidence-based Home Visiting to Prevent Child Maltreatment* (EBHV) grant, to promote a coordinated service continuum of evidence-based home visiting that supports the positive health, safety, and development of young children and their families.

The updated state plan focuses on communities identified as being high risk resulting from social, environmental and health factors that contribute to poor outcomes for young children and their families and builds on the work that was started by the OHV through the EBHV grant. Our mission continues to be building a comprehensive home visiting system.

The first goal focuses on implementing activities that strengthen the infrastructure of supports for home visiting through implementation of evidence based programs, expansion of home visiting to the three identified counties and support programs with necessary trainings and technical assistance. An additional priority is to ensure that home visiting programs operate with fidelity to their selected model.

Goal 1: Implement and strengthen community based home visiting programs in communities at-risk.

Objective 1.1 Increase the service capacity of home visiting programs in Salt Lake, Weber, and Uintah counties by the end of April 2012. Identified communities and models are: Salt Lake Valley Health Department's Nurse Family Partnership Program; Prevent Child Abuse's Healthy Families Program in Ogden; and Utah Parents as Teachers Program in Salt Lake and Uintah Counties.

Objective 1.2 Initiate, in August 2011, a RFP process to identify organizations in Carbon and Washington counties to provide evidence-based home visiting services. Anticipate contracts to be awarded by February 2012.

Objective 1.3 OHV will support implementation activities of funded home visiting programs through training meetings, phone calls, phone conferences, database support and additional activities identified by individual agencies. Support will be offered throughout the duration of the MIECHV grant.

Objective 1.4 Conduct at least two program monitoring site visits a year to ensure high quality service delivery and adherence to model fidelity. The first visit will occur by April 30, 2012 for programs funded with FY 10 MIECHV funds; subsequent visits will be at 6 month intervals. Feedback will be provided following each site visit through a written summary and timeline for addressing any deficiency within 14 days of visit. The first site visit for programs that will be awarded contracts for FY 11 will be six months after the finalization of a contract. The OHV anticipates a contract date of February 2012; tentative site visit date will be August 2012.

Objective 1.5 Provide at least two topical professional development trainings annually. Topics will be identified through program surveys. First survey will be completed by October 31, 2011 and a first training completed by April 2012.

Objective 1.6 Collect and assess quarterly reports from grantees to support continuous quality improvement. Reports will be due 30 days after the end of each quarter. The OHV will provide direct assistance to programs to support this activity.

Objective 1.7 Create a Continuous Quality Improvement team by January 2012 that will support local implementing agencies in using CQI in their programs (see Section 6: Continuous Quality Improvement Plan for more details).

The second goal is to strengthen the home visiting infrastructure through a statewide data and monitoring system. This includes identifying or developing a state home visiting data system that supports evaluation of home visiting programs. The system will target outcomes on identified benchmark areas in order to achieve improvements. OHV will be able to monitor home visiting data to determine if targeted constructs and benchmarks are being achieved annually. It will also provide home visiting data to local programs to support continuous quality improvement.

Goal 2: Develop a data and monitoring system that supports home visiting infrastructure development.

Objective 2.1 Identify through purchase or augment current state system to include collecting MIECHV benchmarks. A state home visiting data system that will support the MIECHV program will be in place by February 2012

Objective 2.2 Identify data tools that collect benchmark information and can be incorporated into the program models by October 1, 2011.
Objective 2.3 Train sites on collecting benchmark data by January 30, 2012
Objective 2.4 Monitor, analyze and report data findings related to the targeted constructs and report back to implementing sites. First agency reports will be due April and October of 2012.

Goal three addresses the larger concern of collaborating with partners and coordinating community support systems. This will feed into creating a statewide early childhood system.

Goal 3: Strengthen home visiting infrastructure through collaborative activities at the state and local level.

Objective 3.1 The OHV will conduct regional community meetings to discuss the MIECHV program, the work of the OHV and the importance of community planning and collaboration efforts. The OHV will train on the use of the *Zero to Three Home Visiting* Planning tool. The OHV will conduct at least two regional meetings by September 30, 2012, using the needs assessment as a guide.
Objective 3.2 The OHV will provide support and technical assistance to implementing agencies on the roll-out of their required community plan. The community plan describes how services such as screening, referral and treatment systems will be coordinated to serve at risk families. The Plan is due October 1, 2011 for communities funded for FY 10. The community plan will be part of the RFP process for FY 11. The OHV will contact individual agencies within 30 days of finalizing any individual contract.
Objective 3.3 The OHV will engage with other state level entities such as the ECCS, Injury Prevention, DCFS Child Abuse and Neglect Council, and Perinatal Task Force. The OHV will identify additional entities and plan to participate at least quarterly in these meetings. The OHV will work with related programs to identify ways to integrate HV into their programs and how they can integrate with the OHV and its programs.
Objective 3.4 Assist local communities in developing home visiting coalitions strengthening existing home visiting or early childhood councils/coalitions. Each funded community will provide a plan for accomplishing this with identified technical assistance needs by October 1, 2011. This is one of the RFP requirements for FY 11 funding.
Objective 3.5 The OHV will spearhead collaborative efforts through ad hoc work groups that address common training opportunities, common intake and evaluation forms, sustainable funding opportunities, social media and website development, and to build constituency support around home visiting, by June 30, 2012.
Objective 3.6 The OHV will develop a Statewide Home Visiting Coalition to address systems building, quality improvement, and support cross-program mentorship by March 2012.
Objective 3.7 The OHV will reconvene the OHV Advisory Committee by November 30, 2011. The committee will meet quarterly thereafter.
Objective 3.8 The OHV Steering Committee will continue to meet quarterly, or more often as needed. The next meeting will occur in November.

How Utah's Home Visiting Program Can Contribute to an Early Childhood System
As an EBHV grantee, the OHV has spent the last three years undertaking the exciting and challenging task of building a home visiting program that has never before existed in Utah. Until

recently, Utah had a patchwork of home visiting models and programs, all with little and uncertain funding, and few with a systematic assessment of need, articulated outcomes, or evaluation of evidence that desired outcomes are achieved. It is the intention of the OHV to weave the informal network of home visiting programs into a comprehensive, coordinated system that responds to the diverse needs of children and families in communities at risk and deliver critical health and development, child abuse and neglect prevention and family support services to them through home visiting programs. As such, Utah's State Home Visiting Program aims to contribute to the development of a comprehensive system by promoting coordinated planning across the agencies that serve to build early childhood infrastructure at the state level as well as to engage at-risk communities in developing local home visiting plans that will that cross social service sectors and engages partners that represent the multiple domains of the early childhood system.

The OHV program priorities, such as improvement in child health and development, and school readiness, fit very well with the components of the early childhood systems work and will serve to enhance what the ECCS grant and the early childhood community have already worked to develop. By supporting more evidence based home visiting programs the state will be able to focus on at-risk first time mothers, giving them the support and services they may need to raise a healthy, well developed baby and young child. It gives us the opportunity to intervene with women before the baby arrives and after to support her and her family in raising the new baby through the critical early childhood years. The earlier the intervention occurs, the greater the success for families.

Integrating the state's home visiting program with other state programs and systems: Current Systems Development Work

The OHV resides in the state Title V agency and as such, the OHV has optimum opportunities to coordinate and link to Utah Title V programs. The Title V Director participates in the planning for this grant and its requirements. Currently Title V contracts a small amount of funding to local health departments to provide what is called "P – 5 Home Visiting". The P-5 Home Visiting services vary from health district to health district. There is not sufficient funding to utilize any of the evidence based models as defined by this grant. So, each district determines the need for services and type of services to provide based on their resources, which may include county funding. The state's Title V funding supports home visiting to high risk families and is used by many of the local health departments as an adjunct to the state Medicaid Targeted Case Management (TCM) services. TCM services, which may include a home visit, are not designed to provide hands-on services, but rather to ensure that children under age five receive needed health services. The TCM Medicaid reimbursement rate is higher than what the P-5 funding would cover so generally local health departments start a Medicaid family with TCM services and then supplement services through the P-5 Home Visiting funds.

The alignment of programs within the DOH will enable the OHV to better fulfill its mission statewide due to easy access and close collaboration with other state entities with similar goals. For example, in the Bureau of Maternal and Child Health (MCH) , a sister bureau of the BCD, the Maternal and Infant Health Program tracks pregnancy outcomes, including pregnancy spacing, impact of certain factors on birth outcomes, such as obesity, and so on. With the integration of MCH, the OHV will have access to a broader array of knowledge and experience, such as clinical staff, administrative staff, etc., which can assist the OHV in developing plans for services. Other programs that the OHV will coordinate with, and link to, are WIC, Pregnancy Riskline programs and Oral Health initiatives.

The staff of the OHV participates in the Early Childhood Comprehensive Systems (ECCS) grant activities and co-chairs the Parent Education and Family Support (PEFS) component of this grant. Through its collaboration with the ECCS grant, the OHV provides the capacity to ensure that home visiting is built into the developing system work of the ECCS grant. There is no formal early childhood system at the state or local level in Utah but the members of the ECCS work group are in the process of establishing concrete goals to integrate activities across the various early childhood sectors. One important goal is the integration of early childhood data. The BCD Bureau Director, who is administrator of the ECCS grant, has convened ongoing meetings with various state entities to explore the practicalities and realities of data integration which would create the ability to monitor child outcomes longitudinally and to improve service delivery. With the OHV in the process of developing a state home visiting data base, staff has been participating in data integration discussions with the ECCS work group.

Another example of systems development work is the possible expansion of *Help Me Grow* (HMG). HMG consists of four components:

- Training of child health providers in effective developmental surveillance;
- Creating a resource inventory of community-based programs supporting child development and families;
- Developing a coordinated, statewide system of referral that links young children and families to exiting services and support; and
- Collecting data and analyzing of children's developmental status and statewide resources.

In the coming budget year the PEFS sub-committee of the ECCS work group will explore the expansion of HMG into Salt Lake County. The United Way of Utah County is currently implementing HMG. Utah County borders Salt Lake County to the south. The United Way of Utah County is developing stronger ties to the Salt Lake City 211 system to expand the resource database and eventually expand *Help Me Grow* statewide. Referrals and linkages to appropriate home visiting programs could be maximized through HMG. The Salt Lake County 211 system is operated by United Way of Salt Lake as of June 2011. HMG is in the process of making greater collaborative moves to interface resource information with Salt Lake County. *Help Me Grow* in Utah County is a replication of Connecticut's *Help Me Grow* Program. It is an integrated identification, resource and referral system for families, providers and programs. Referral and linkages to appropriate home visiting program could be maximized through the HMG system.

OHV staff and the Department of Human Services, Division of Child and Family Service's (DCFS), Child Abuse Prevention Administrator are coordinating, planning and sharing accountability for funding home visiting programs. A recent and positive outcome of this coordination is the development of an interagency revenue agreement which allows for DCFS to transfer some of their Community Based Child Abuse Prevention (CBCAP) funds to the OHV to support the implementation of home visiting programs. Additionally, DCFS is collaborating with the OHV on the development of joint language to streamline and coordinate the sub-contracting process for communities applying for funding of home visiting programs.

The BCD recently hired a Child Development Specialist who is tasked with working with state and community partners that serve young children to incorporate use of the ASQ-3 and the ASQ-SE tools within their agencies. The results from the use of this child development screening instrument will be maintained in a state data system provided by the developers of the ASQ. The state home visiting programs are already using the ASQ. The OHV, through its database contractor, will develop an upload to the state ASQ system providing for uniform assessment of children's development statewide.

The development of Utah's Early Learning Guidelines is the culmination of a three year collaborative project among the State Office of Education, the Utah Family Center and the Department of Workforce Services Office of Child Care. The guidelines were developed to help families, educators and communities make informed decisions about curricula for pre-K children. These early learning guidelines describe specific, research-based objectives for pre-kindergarten children in five basic content areas. The implementation of these guidelines in the home and in early childhood programs will improve transition to kindergarten and reduce achievement gaps. This work creates an opportunity to strengthen cross-systems efforts by aligning all work with young children under the same set of early learning guidelines.

Section 3: Proposed State Home Visiting Model(s) and Explanation of How the Model(s) Meets the Needs of Identified Communities

Utah currently implements, in several communities, four of the seven nationally approved evidence-based home visiting models in operation: Nurse Family Partnership (NFP), Healthy Families America (HFA), Parents as Teachers (PAT), and Early Health Start (EHS).

Recognizing that no single home visiting model can meet the needs of all communities, Utah's MIECHV state plan will adopt a multi-model approach to home visiting that will include: NFP, HFA and PAT. It was a difficult decision by the OHV not to include EHS for funding with the MIECHVP funds. In the end, the decision was a pragmatic one based on available funds. While funding for EHS in the state is often insufficient to serve all eligible families, it does have a steady funding source through the federal Head Start agency and the cost per family for EHS is more than twice the cost of the other home visiting models. NFP, HFA and PAT programs in Utah will rely almost solely on the MIECHV funds.

In FY 11, the Office of Home Visiting will support home visiting programs with the MIECHV funds to:

- Salt Lake County: NFP and PAT
- Uintah County: PAT
- Weber County: HFA
- Washington County: PAT or HFA (to be determined through an RFP)
- Carbon County: PAT or HFA (to be determined through an RFP)

These five counties have high incidences of numerous risk factors such as teen pregnancy, pre-term and low birth-weight babies, higher than average school drop-out rates, and poverty, a strong predictor of poor outcomes for children. The evidence-based home visiting programs in these counties all have waiting lists.

After the release of the first SIR, the OHV Steering Committee (see Section 1 for committee membership) began to discuss which models that might be approved by HRSA as evidence-based. Early in the planning process, the Steering Committee expressed strong interest in the Triple P Parenting Program which has demonstrated positive outcomes. As a result of the interest in Triple P, the OHV hosted a day-long training on the Triple P Parenting Program. Ron Prinz, from Triple P America, was invited to present to a group of state and community level partners. While the information provided was compelling, the Steering Committee decided that the model was not appropriate for the OHV to fund and implement due to the fact that the program has many components that are not home-based. In the end Triple P was not included in the list of approved evidence-based models as determined by HRSA.

After the release of the 2nd SIR and HRSA's approval of the evidence-based models, the OHV and Steering Committee met and finalized selection of models for the Utah State Plan. The following paragraphs in this section detail Utah's process for selecting the appropriate models.

To determine the viability of implementation of the existing programs in five identified counties, the OHV contacted the model developers to gauge their support for program expansion in the targeted programs. Section 4 describes communications with the national model developers.

Each of the home visiting programs in the targeted communities were and are serving families at capacity and continue to receive referrals, resulting in waiting lists. Through its regular communication with the home visiting programs in the targeted communities, the OHV learned that program referrals come not only from community referral sources but from families themselves indicating a strong need for services in the identified communities. Utah's existing home visiting programs are serving only a small percentage of potentially eligible families and expansion of existing services would be welcomed by the programs, the community and the families.

Based on the crosswalk developed by Mathematica, the OHV examined the evidence-based models and their outcomes. It was clear that NFP, PAT, and HFA closely aligned with the identified risk factors noted in the at-risk counties (please refer to www.homvee.acf.hhs.gov). Section 1 of this application provides detail on the specific risk factors present in each of the communities. In addition, the community readiness interviews conducted by the OHV and discussed in more detail in the next sub-section indicated the need for expanding the home visiting programs in the targeted communities.

In sum, the existence of an evidence-based program in the targeted communities was one factor in model selection. The second was the readiness and capacity of the individual programs to expand with fidelity and quality. Lastly, the OHV and its Steering Committee compared the outcomes associated with the existing models with the data from the statewide needs assessment and determined that the current models did meet the needs of the community and addressed the risk-factors present in those communities. It was therefore determined that it

was more prudent to expand the existing programs rather than fund the implementation of a new home visiting model and program.

Process for engagement of at-risk communities

Recognizing the need for community engagement the OHV staff conducted a research-based community readiness survey, *Community Readiness: Handbook for Successful Change*, in the targeted communities of Salt Lake and Weber counties. The OHV Steering Committee reviewed and supported the use of the survey tool and assisted in developing a list of appropriate contacts. OHV staff interviewed key partners in the targeted communities. Interviewees included staff from Part C Early Intervention programs, local child welfare agencies, local substance abuse agencies, Family Support Centers/Crisis Nurseries, local health departments and Children's Justice Centers. Results were compiled and presented to the Steering Committee. The results of the survey allowed the OHV to better understand gaps in current services and perceived needs of the community. A summary of responses indicate that there is a need for prevention services targeting at-risk families rather than services for families after an incident has occurred. An example from respondents indicated that there was a lack of parent support services for families and data show high rates of child abuse and child poverty. Lastly, early intervention services are available for young children with moderate developmental delays and/or disabilities but few services for children and families with less severe delays or at-risk for other reasons. In total, the results from the community readiness survey indicated that the targeted communities were ready and supportive of evidence-based home visiting programs in their community.

Due to personnel changes within the OHV in the spring of 2011 the process of visiting targeted communities was put on hold until new staff was hired, which occurred in August of 2011. In September 2011 OHV staff attended community forums in both Carbon and Weber Counties. The meetings were well attended with a broad range of community representation. Both counties have strong collaborative relationships across many service sectors to address the needs of vulnerable children and families within their respective communities. In addition, attendees in both counties were excited and supportive about the prospect of expanding the service capacity of the existing home visiting services in their area rather than implementing a program within another agency. The OHV staff plan to conduct community forums in Uintah and Washington counties by the end of October 2011.

Uintah County will be included in these community forums since this did not occur prior to the submission of the previous application. These community forums will provide the OHV with an opportunity to engage local stakeholders, including parents, in understanding the potential opportunity available through the MIECHV program. Ideally, the OHV will learn how engaged the community is in implementing an evidence-based home visiting program, where the strengths and weakness may lie in implementation, and in what areas technical assistance might be necessary. The OHV plans to conduct these community forums annually with the current targeted communities. Regional community forums will be conducted with those that may be eligible for funding in outgoing years.

The Office of Home Visiting has developed a Request for Proposal (RFP) process to fund a home visiting program in Carbon and/or Washington counties. The RFP requires applicants to provide a plan for development of collaborative community partnerships and a commitment to improvement of the local early childhood system planning.

The OHV will use a combination of the *Zero to Three Home Visiting Planning Tool* and the community readiness survey tool previously used to guide the community meetings. To provide an opportunity for open-ended discussion, the OHV evaluator will develop several questions to pose to the community to elicit feedback. Invitees to the community forums will include parents, community leaders, representatives from the local child welfare agency, county health departments, Part C Early Intervention, home visiting programs, Family Support Centers, religious communities, mental health and substance abuse agencies, parent support programs and school districts.

Additional Community Engagement

In April 2011, the OHV convened a meeting with the home visiting programs in Salt Lake County, along with other early childhood stakeholders, to discuss the development of a local home visiting plan based on the statewide needs assessment. The meeting also included a discussion of agency readiness and ways to improve cross agency collaboration to better utilize the limited resources available to families in the county. In addition, the OVH staff met, individually and jointly, with the NFP and PAT programs to discuss the information about the targeted communities as required by the SIR such as community strengths and risk factors; characteristics and needs of participants; existing home visiting services in the community: mechanisms for screening; identifying and referring families and children to the home visiting programs in Salt Lake County; and referral sources currently available and needed in the future to support families.

NFP/NSO requires that each potential implementing agency conduct outreach to communities by convening diverse stakeholder, providing basic education about the model, encouraging communities to do their own local needs assessment, and reviewing current community programming by estimating the size of the eligible populations. The NFP program in the Salt Lake Valley Health Department began its community outreach process in 2007. In addition to working with community partners, the local health department staff hosted a community forum where a representative from the NFP/NSO presents on the NFP program and its outcomes. Once the Health Department determined that it was going to begin implementation, staff held a televised press conference with the County mayor as a speaker. The County Mayor had supported implementation of the NFP program and actually found the initial funding to start the program.

In addition, local NFP programs are required to develop Community Advisory Boards to build strong, broad and high-level support from individuals and organizations in the local community. Salt Lake County's Community Advisory Board is made up of: OHV, United Way, University of Utah Department of Pediatrics, Salt Lake Valley Health Department, Zions Bank, Part C Early Intervention, Salt Lake County Substance Abuse Services, March of Dimes, Salt Lake City Office

of the Mayor, Salt Lake City and Granite School District's Early Childhood Specialists and the PAT program. The OHV is an active member of this Board and periodically gives presentations on its work.

The PAT Essential Requirements for an affiliate program include the development of an advisory committee to include program personnel, community service providers, community leaders, families, and other stakeholders. Utah PAT has worked with its communities to develop referral sources for the program which has built community engagement and support. The OHV staff participates on the UPAT Advisory Board and has made presentations to members on home visiting and the work that the OHV is undertaking.

Prior to the implementation of the Healthy Families program in 2008, Prevent Child Abuse Utah in Weber County and a coalition of community partners that serve pregnant mothers in the county determined the need and garnered support for the implementation of the HFA program. It was determined that the HFA program would provide services for a population known to need more services than existed at the time: first-time pregnant mothers with risk factors. Not only did the data indicate high need in certain areas of Weber County but community partners had first-hand experience in understanding that the existing services did not meet the needs of the most vulnerable in the county. Programs that did exist were short term and did not have the capacity or training to provide more continuous involvement to ensure the child's and parent's needs were met and supported. In September 2011, the OHV attended a community coalition meeting in Weber County, with broad agency representation and families. Meeting participants were very supportive of the Healthy Families program expressed strong interest in keeping the program going and expanding the program to reach more families. There was strong consensus that a change in current eligibility of the HFA program was needed. Under current funding, the HFA programs serves only first-time mothers and under the MIECHV program eligibility will be expanded include pregnant women who have other children.

The "Healthy Moms" coalition, a Weber County coalition of community partners, was created for the purpose of serving Healthy Families Utah as a community partner for referrals and as an advisory board. The original members were funders, community partners and referral sources such as St. Benedict's Foundation, Intermountain Healthcare, McKay Dee Hospital, Ogden Regional Medical Center, and Mid-town Community Health Center. The coalition has since expanded from these entities into a larger community resource composed of representatives from various agencies in Weber County including: Healthy Families Utah/Prevent Child Abuse Utah, Weber County Health Coalition, DCFS, Weber Human Services, Weber State University, Children's Justice Center (CJC), Ogden City Police Department, Salvation Army, Second District Court, Utah Foster Care, Ogden and Weber School Districts, Utah School for the Deaf and Blind, and the local community health center.

In addition to family referrals, the coalition collaborates to better serve the community by providing a network base that directs families to the appropriate resources that will best meet their particular needs. The Healthy Mom's Coalition meets every month to coordinate existing community services and explore the development of new programs depending on the needs of

the community. The most recent programs that have been organized through Healthy Moms include a substance abuse support group for women through the Salvation Army, a teen advisory committee through Ogden and Weber School Districts, a teen parent support group through Healthy Families Utah, drug endangered children's education and support group through DCFS and CJC, and parenting classes for families who are not "in the system" but feel they could benefit. These classes are provided by various agencies in the coalition. The most recent event that the Healthy Mom's Coalition organized was the *Drug Endangered Children's Conference* which was a great success. The speakers provided a wide array of information ranging from a medical prenatal perspective to the long term adverse effects on the lives of drug endangered children. OHV staff will attend the Healthy Moms Coalition biannually.

Prevent Child Abuse Utah has been a strong and visible partner in the state and its resident community in preventing child maltreatment and promoting policies and programs that support parents and children. They were, therefore, a logical choice for the implementation of an evidence-based home visiting program.

Attending the advisory board meetings presented an opportunity for the OHV to educate the community about the MIECHV overall grant, the goals and expectations and current and future funding opportunities for communities. The OHV will continue to engage the members of the targeted community through participation in program advisory boards or councils, act as a point of contact with local early childhood or home visiting coalitions, and conduct semi-annually regional community meetings.

The following paragraphs provide a description of the program models chosen for implementation.

The Nurse Family Partnership model is designed to give first-time mothers valuable knowledge and support throughout pregnancy and until their babies reach two years of age. The program partners first-time moms with caring nurse home visitors who empower these young mothers to confidently create a better life for their children and themselves. Nurse home visitors focus on providing support to moms to have a healthy pregnancy, to improve the child's health and development and to become more economically self-sufficient. These primary outcomes are associated with preventing child abuse, reducing juvenile crime and increasing school readiness.

The Parents as Teachers model is designed to serve families throughout pregnancy until their children enter kindergarten. Communities may be identified as particularly in need of home visiting because of demographic data (e.g., level of infant mortality, poverty, or low educational attainment) or geographic characteristics such as isolation or lack of accessible resources. The PAT model is adaptable to varied target populations and communities, and affiliate programs serve families with a range of risk factors. The PAT model is designed to promote positive parenting and optimal child development and build protective factors for families from a range of backgrounds. PAT serves a broad range of families with high needs, not just first-time parents, pregnant parents or teen parents. The PAT Foundational Curriculum is a good fit for addressing the needs of many targeted at-risk populations and incorporates the Strengthening Families Protective Factors.

The PAT model provides a cohesive package of services with four primary goals:

- Increase parent knowledge of early childhood development and improve parenting practices.
- Provide early detection of developmental delays and health issues.
- Prevent child abuse and neglect.
- Increase children's school readiness and school success.

Model components are integrated to promote parental resilience, increase knowledge of parenting and child development, and encourage social and emotional competence of children—all vital protective factors.

Nurse Family Partnership and PAT Coordination

NFP and PAT both serve the communities within Salt Lake County. NFP targets low-income first-time pregnant mothers. NFP has been serving families since 2008 and is funded to serve 125 families. According to UDOH data, Salt Lake County has over 1,000 women that would be eligible for the program indicating that the program is serving approximately 10% of the eligible populations.

While NFP has achieved many successes and plays an important role in promoting positive maternal and child health outcomes, the eligibility requirements for the program are very restrictive. A mother must be a first-time mother no further along in her pregnancy than 28 weeks', limiting many mothers' access to needed home visiting services. Because of these eligibility requirements we recognize that Salt Lake County needs more than one program model to meet the diverse needs of the community.

The Salt Lake NFP program coordinates its referral process with the PAT program. If a woman is referred to NFP but does not meet the eligibility requirements NFP makes a referral to PAT. PAT, as a model has universal eligibility however they prioritize first-time mothers and very high risk pregnant mothers.

The OHV believes that expanding the services of these two program models will target the families most in need of home visiting services and lead to further coordination between the programs. While Salt Lake County's EHS programs are not receiving grant funding at this time, NFP and PAT are encouraged to plan and coordinate with those programs.

Healthy Families America is a home visiting program designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. HFA services begin prenatally or right after the birth of the baby and are offered voluntarily, intensively, and over the long-term (3-5 years after the birth of the baby).

The goals of the program are to:

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth;
- Cultivate and strengthen nurturing parent-child relationship;
- Promote healthy childhood growth and development; and
- Enhance family functioning by reducing risk and building protective factors.

Utah's Experience with Implementing Nurse Family Partnership, Healthy Families, and Parents as Teachers

The OHV has a close, collaborative relationship with the NFP, HFA, and PAT programs supporting their implementation through technical assistance, training, funding, and development of a coordinated data collection system to monitor and report on statewide outcomes.

The Salt Lake Valley Health Department began implementing the NFP program in 2008. The NFP National Service Office reports that the NFP program is exceeding expectation for implementation and has demonstrated very positive outcomes for families in the program. Key informant interviews conducted by the OHV indicate that the NFP supervisor and home visitors are committed to the program and feel that the NFP NSO provides extensive support to ensure quality implementation of the program. In 2010, the NFP program served over 100 women.

Healthy Families America has been in operation in three communities in Utah since 2008, Weber County being one of those communities. All three programs are currently going through the accreditation process and are in good standing with the HFA National Office. The OHV has knowledge of the program and the agencies implementing the HFA model, and meets often with the program staff. Combined, the Healthy Families programs served more than 100 children and their families through three programs since their inception.

Utah PAT affiliate programs have been supported through a nationally designated state program office for close to a decade. Utah PAT 2010 annual report indicates it served 290 families in Salt Lake, Cache, Utah, and Uintah counties.

Washington and Carbon Counties have both been operating Early Head Start Programs. However, as explained earlier in this document, the state home visiting program has chosen not to include EHS in its MIECHV program. Utah's needs assessment indicated that Washington and Carbon counties had many risk factors and will have an opportunity to apply to implement a Healthy Families America Program or Parents as Teachers Program. The number of families that the program can serve will be addressed through the program's RFP responses to the OHV.

The OHV and its RFP selection committee will make a final funding decision that aligns with the state's goals and objectives and meets the requirements of the FOA. Once a final decision has been made, the OHV will execute a contract with the local agencies to implement the chosen model(s). The timeline for this process ensures program implementation by October 1, 2011 for FY 11 funded programs and February 2012 for FY 11 funded program.

Utah's Plan for Ensuring Implementation, with Fidelity, to the Models

The OHV will support implementing agencies in maintaining fidelity to and quality of the home visiting program model and monitor these programs on an ongoing basis. Fidelity measures are built into the application process. Each currently funded agency applying for MIECHV funds is asked to submit a detailed explanation of how they plan to maintain fidelity to their specific model

and how they plan to work with the model developer. In addition, the OHV will monitor contract performance and data outcomes, and provide and coordinate training and technical assistance.

The application process for FY 10 funding and RFP process for FY 11 funding will require organizations to respond in detail to their ability to implement the evidence based home visiting program. Potential contracting agencies will be asked, among many other things, to indicate their plans to adhere to model specific requirements including:

- Target population
- Staff qualifications
- Staff training and supervision
- Frequency and duration of home visits
- Caseload
- Management of quality

Successful applications will result in a contract with the OHV for funding for implementation of a specified home visiting model. Contractors will be required to submit quarterly reports and an annual report. Reports will include information related to process and outcome measures. A reporting format still needs to be developed by the OHV; an anticipated completion date is the end of December 2011. The OHV is developing a data management system that will track administrative and client level data.

The OHV will monitor contracts on an on-going basis and require agencies to participate in continuous quality improvement process. The OHV's plan for Continuous Quality Improvement can be found in Section Seven of this document.

Recognizing that each applicant may have a varying level of capacity to support model fidelity, the OHV intends to provide ongoing support, in conjunction with the model developers to ensure program success. A benefit of implementing evidence-based programs is that they are affiliated with nationally developed, evidence-based home visiting models that provide resources for quality assurance and supports for implementing and maintaining model fidelity.

Contracts with the OHV will help to ensure that the implementation of NFP, HFA, and PAT programs follow the fidelity and quality assurance requirements of their national developers detailed later on in this sub-section. The OHV has established a relationship with the NFP and HFA national program liaisons and with the PAT state intermediary. Monitoring activities for OHV-funded programs will be coordinated with the model intermediaries or national model liaison to ensure implementation fidelity through progress reports, technical assistance, and consultation and site visits from the model representatives.

Anticipated challenges and risks of the programs and the proposed response
One challenge for the OHV may be the timely completion of the RFP process due to the lengthy processes that are required in a bureaucratic system. OHV staff will monitor the process closely and frequently follow-up with personnel responsible for completing the approval process.

Utah is an international refugee resettlement site. Most refugees, although not all, live in Salt Lake County. While the numbers of individuals representing different racial and ethnic groups are not large, there are many different ethnic groups represented among those that have been relocated to Utah. All of the racial and ethnic groups speak their own language. It will be very difficult to find qualified staff that can speak these individual languages. Developing a collaborative relationship with the Asian Association of Utah (discussed in the previous section) will be beneficial in addressing this challenge. Technical assistance from the state and national level will be provided to support a program in reaching fidelity and supporting quality implementation. The OHV will require subcontractors to outreach to and develop partnerships with agencies such as, the Indian Walk-in Center, Refugee Health, the Asian Association and the Indian Health Services.

As previously stated, the targeted communities have existing evidence-based home visiting programs with established partnerships within their respective communities. Each community recognizes the importance of strong community partnerships and a comprehensive system of supports and services to improve outcomes for families. The communities strive to be inclusive and build partnerships with referral sources and community agencies that provide needed services to families.

Section 4: Implementation Plan for Proposed State Home Visiting Program

Utah's MIECHV program includes a continuation of funding for the identified communities and programs through the MIECHV FY 10 allocation and a Request for Proposal for a funding an evidence-based home visiting program in Carbon and Washington counties with the additional funds allocated to Utah in FY 11.

The communities have a demonstrated need for additional home visiting services based on needs assessment data, community readiness and planning process, and long program waiting lists. The national offices of NFP, PAT and HFA are aware and supportive of Utah's implementation plans. The OHV will support program implementation through collaboration with the model developers, providing implementation technical assistance and program monitoring. PAT is fortunate to have a state office that can provide on-site program support to ensure implementation fidelity and quality programming.

A process for engaging at-risk communities around the proposed plan identifying organizations and other groups

A description of the process for engaging the at-risk communities has been provided in Section Three. Continued infrastructure development and systems building at the local level will be supported by the OHV in Salt Lake, Weber, and Uintah, Carbon and Washington Counties through technical assistance.

In addition to what was describe in Section Three, OHV staff attend various community and state agency meetings and used these meetings as an opportunity to discuss the proposed home visiting plan. Examples are the Utah Perinatal Taskforce, Safe Kids Coalition, Salt Lake City Mayors Literacy Council, NFP and PAT Advisory Boards, local health department's Nursing

Director's monthly meeting, local health department's Health Officer's meeting and the Family Support Centers Director's monthly meetings.

The OHV's Community Advisory Committee was engaged in the development of the MEICHV state home visiting plan. Committee membership includes representatives from home visiting programs, county and state level maternal and child health programs, Injury Prevention Program, state Division of Substance Abuse and Mental Health, past director of the Department of Health, Division of Family Health and Preparedness, CBCAP Program Administrator, Voices for Utah Children-a state child advocacy organization- Medicaid, Head Start State Collaboration Office, United Ways of Utah, and the Utah State Office of Education.

Utah's MIECHVP also supports further integration of home visiting at the state level. The OHV will use the opportunity to leverage the multiple early childhood partnerships that already exist and develop relationships at the state and local level throughout the next year. The state will take an active role in supporting sites to develop and strengthen community partnerships by identifying key partners, coordinating information amount partners, and providing technical assistance. OHV staff will attend home visiting program advisory boards, community coalition meetings, and continue to seek input from the targeted communities through regional and local community meetings. The cycle of ongoing community engagement will be replicated each year as appropriate.

The OHV is implementing a website and social media form that can be a virtual gathering place for community partners and families. The website is currently in operation and the social media piece will be added by June 2012. The site will give programs and individuals a place to ask questions, share information and insights and join together.

The model developers understand the important role of community engagement in program sustainability and quality implementation and require local programs to establish community advisory boards or committees whose membership reflects the community and its stakeholders. In addition to a program advisory board, each targeted community will be encouraged to participate with an early childhood council or community collaboration group to develop new community partnerships and to identify alternative ways to build coordination and collaboration in the community.

Utah's Approach to Development of Policy and to Setting Standards for the State Home Visiting Program

At this time, the OHV will rely on the standards and policies developed by each model developer as guidelines for the state program. Each funded program will provide a plan that details the specific policy on: frequency and durations of visits; adherence to selected curriculum in conformance to program model; family recruitment, selection and enrollment; home visiting staff recruitment, selection, training; appropriate supervision and plan for providing reflective supervision; data collection and records, and evaluation and monitoring of outcomes. Details of the subcontract implementation plan are listed in Section Three of this document. The OHV will work in close partnership with the model developers and the PAT state

office to ensure that state-level policies or standards do not contradict any model-specific policy or standard. OHV will require that all programs adhere to the policies and procedures of their selected model program. All subcontractors will be required to share their application plan with the respective model developer.

We recognize that the State will need to develop policies and set standards to guide the state home visiting program. Over the next six months the OHV Steering Committee with input from the local home visiting programs will convene an initial meeting to explore areas of potential policy development. Some topic areas include the following areas:

- Data security and confidentiality;
- Confidentiality related to program and state level staff;
- A common set of data collection tools and frequency of use
- Reporting requirements to demonstrate model fidelity;
- Contract monitoring policies including monitoring tools and corrective action standards;
- Establishment of core competencies for home visiting program staff ;
- Agency Director role and training requirements.

Since the MIECHV program includes a multi-model approach, the OHV is working to develop a core set of outcomes for all home visiting programs and common fidelity requirements that all programs must achieve in order to cross-evaluate individual programs and to conduct a statewide review of home visiting.

Model Implementation Plans

The OHV Program Coordinator, Program Specialist and Internal Evaluator, along with input and oversight from the OHV Steering Committee, will oversee the implementation of the home visiting programs. OHV staff will collaborate with program management and representatives of the national home visiting models and conduct monthly site visits for the first six months of implementation to monitor local program progress. The OHV staff and the Steering Committee will meet monthly during this time so that they are kept abreast of implementation challenges and successes and have the opportunity to provide input for any issues that may arise. OHV staff, program supervisors, and national model developers will communicate via conference call monthly for the first year to discuss implementation and program operations issues.

The newly formed State Home Visiting Coalition will provide a mechanism to identify and resolve program with outreach, enrollment, service coordination and other implementation issues, and act as an information exchange for sharing best practice, lesions learned and problem solving. Coalition Membership will include OHV staff, and representatives from each home visiting program throughout the state. This group will initially meet monthly and then move to quarterly meetings.

The OHV will also monitor program activity through its database and provide monthly reports, along with information from the site visits, to each implementing agency so they can assess program implementation and make corrections accordingly.

A clear advantage of implementing evidence-based models is their established protocols for site selection, implementation, training, monitoring, CQI and evaluation. Utah's evidence-based home visiting programs are part of strong, well established national programs, and in the case of PAT, a strong intermediary organization at the state level, that provide model specific support through consultation and technical assistance. Implementation of program expansions will follow the protocols and recommendations for each model as illustrated in the table below.

Table 7

SIR requirement	Model	National Model's role	OHV's role	Timeline
Recruitment of qualified staff	NFP	Defines competency, professional credentials, cultural and personal assets. Provides specific job descriptions.	Tracks identification of qualified staff; will work with Utah nursing programs to educate student nurses about NFP as a career option. The OHV requires the subcontractor to submit its plan for recruiting qualified staff. The OHV requires that programs meet the staff qualification standards set by their home visiting model. The OHV will monitor this through record checks during the site visit	Staff hired by November 15, 2011 for the HFA, NFP and PAT programs funded for FY 10. Staff hired by an estimated date of April 2012 for the programs funded in FY 11.
	PAT	Defines qualifications for Parent Educator as at least high school diploma or GED plus 2 years experience working with children or parents; recommends Bachelor's degree	Provide TA in recruiting bi-lingual Spanish-English Parent Educators	Needed support will be provided as needed beginning October 1, 2011 and again in April 2012.
	HFA	Defines qualifications of home visitor as at least high school diploma, plus defined experience and personal characteristics.	Existing programs have contract with DCFS that requires Bachelor's degree. Provide TA in recruiting BA level, bilingual Spanish-English Home Visitors. Since home visitors are	

			not employees of the state it is each programs responsibility to recruit qualified staff. OHV will provide professional development in an effort to retain staff. OHV is reviewing the process in offering long term staff incentives for continuing with the program.	
Core model training	NFP	Requires multi-step orientation and education process provided only by the NFP National Service Office.	OHV will fund and provide logistical assistance.	Staff trained by January 30, 2012 for programs funded in FY 10. Staff trained by an anticipated date of July 2012 for programs funded in FY 11.
	PAT	Requires and provides PAT Foundational Training.	Will fund and assist with logistics to arrange in-state Foundational Training	
	HFA	Requires and provides Core Training.	Will fund and assist with logistics.	
On-going training	NFP	Provides on-going site-specific training and technical assistance through its Regional liaison.	OHV will survey implementing local agency needs and provide corresponding training via sub-contract with PAT and other collaborative methods.	The OHV will provide topic specific trainings semi-annually beginning in April 2012. *The OHV originally planned to provide trainings on a quarterly basis, as indicated in the FY10 plan, however upon reflection semi-annually seems more realistic.
	PAT	Requires 20 hours of professional training annually. Offers annual and state professional development conferences; has a state office that provides on-going T & TA.		
	HFA	Requires specified hours of on-going training annually. It offers annual and regional professional development conferences; provides technical assistance through a regional liaison		
Providing clinical supervision	NFP	Defines maximum supervisor case-load; requires weekly 1-hr. clinical and reflective supervision, monthly	Subcontractors are required to submit a plan their plan for providing clinical supervision and reflective practice. The	Site visits will be scheduled for March 2012 for programs funded in FY10.

		team meetings, twice monthly administration meetings and field supervision.	OHV will contractually require clinical supervision and provide annual training on reflective practice. The OHV will contractually require consistent documentation of clinical supervision in the OHV database. OHV will monitor rates of clinical supervision through the database. Quality of supervision will be monitored through semi/annual interviews with staff in conjunction with the site visits.	Programs funded with FY11 funds will receive their first site visit six months after a formal contract has been established. Anticipated date for the first site visit is August 2012.
	PAT	Defines maximum supervisor case-load; requires 2 individual supervisions per month, plus two staff meetings.		
	HFA	Defines maximum supervisor case-load; requires 1.5 hours clinical, supervision per week.		
Identifying & recruiting participants	NFP	Eligibility: first-time, low-income mothers before 28th week of pregnancy. Provides a database of successful outreach and recruitment practices.	The OHV requires subcontractors to submit letters of commitment from recruitment sources and time-lines for reaching full enrollment. The OHV will monitor enrollment through OHV database and provide TA to assist in recruitment challenges. Will provide training on family risk assessment. As part of its TA, the OHV will work with potential referral agencies to educate and inform about the home visiting programs and facilitate creating partnerships to maintain and increase the referral stream.	Full case load 6 months after hire date.
	PAT	Universal eligibility with flexibility to meet local needs.		
	HFA	Eligibility: pregnant women and children birth – 3 who are identified by standardized assessment as at-risk for poor outcomes such as child maltreatment. Services must be voluntary. Recruitment strategies are part of core training. Creative outreach allows engagement with high-risk, difficult-to-reach families over a 3-month period.		
Minimizing attrition rates	NFP	NFPNSO database monitors attrition. Regional liaison provides analysis of data to minimize attrition.	The OHV will monitor attrition rates through the OHV database and quarterly reporting. The OHV will provide TA to identify causes and improve retention.	Attrition rates will be monitored during annual site visits and through quarterly reporting to the OHV. This applies to all programs.
	PAT	Requires calculation of		

		attrition rates annually.	OHV will provide training on how to retain vulnerable families to minimize attrition. OHV will also support professional development to retain staff because losing staff is a major contributor to families leaving the program. Subcontractors are required to submit a participant retention plan that includes solutions to this challenge.	Retention plan will be reviewed annually and issues will be addressed through technical assistance, support, cross-program mentoring and continuous quality improvement measures.
	HFA	Requires analysis of acceptance and retention rates at least every 2 yrs.		
Coordination with other family resources	NFP	Requires community advisory board representing a range of health and family service providers. Requires coordination through case management.	Will formalize relationships with state divisions and departments into written MOUs that will provide templates for local MOUs formalizing collaboration.	MOUs and advisory committee/board agendas monitored at site visit March and August 2012.
	PAT	Requires that referral to community-based services be part of each home visit, as needed and desired by family.		
	HFA	Coordination with other health and family service providers is a required critical element.		
Continuous quality improvement	NFP	Requires periodic reports on key elements; provides TA by regional liaison to ensure compliance with fidelity and quality issues.	Will require periodic reports through OHV database, and will provide TA to programs to remedy fidelity and service quality issues. Will ensure that OHV data system can generate all reports required by model developers, or will enter into data-sharing agreements with local contractors to access each model's data management system	Monthly database monitoring to be completed the by 10th of the following month. Written feedback will be provided by the OHV within 2 weeks. The OHV will provide CQI training to all funded implementing agencies by the end of the first quarter of 2012.
	PAT	Visit Tracker data management system provides periodic reports to local site re: fidelity and quality issues		
	HFA	PIMS data management system provides periodic reports to local sites re: fidelity and quality issues.		
Number of	NFP-Salt Lake	# 50 families to be	The number of families to	

Families to be Served	County	served with FY 10 MIECHV funds.	be served is based on the FY 10 funding. Changes in the number of families will depend on attrition and graduation rates.	
	PAT	#72 families to be served with FY 10 MIECHV funds.		48 SLC site 24 Uintah site
	HFA-Weber County	#60 families to be served with FY 10 MIECHV funds.		
	Washington and Carbon Counties	The number of families served will depend on the results of the RFP process including # of many programs funded and model they choose to implement.		

Local Level Implementation Information

Nurse Family Partnership

The NFP program offered through the Salt Lake Valley Health Department (SLVHD) has been operating successfully for 3 years and has strong relationships with various community partners that act as referral sources for the NFP program. NFP supervisor and nurse teams continually engage in community outreach activities to inform individuals and groups about the program and encourage referrals. The program's community-based Advisory Board that provides local support and outreach. Referral partners include pregnancy testing centers, WIC clinics, Medicaid enrollment sites, schools, and primary care providers.

The Utah NFP program monitors attrition rates through the NFP NSO database. Each NFP site must submit an annual progress report evaluating performance on the model elements and program outcomes, including client engagement and retention. Sites analyze attrition rates and devise strategies to address the causal factors in other cases, nursing interventions are examined and strategies are directed at improving those interventions.

The NFP NSO provides continuous quality improvement and evaluation, supported by a robust data collection and reporting system that provides information about program implementation fidelity, client intervention and maternal and child outcomes. NFP collects information on family characteristics, needs, services provided, and progress toward accomplishing program goals. Client level data is collected according to schedule by nurse home visitors during visits. Regular quality reports are provided to ensure data are complete and accurate. Local, state and national data are provided regularly to local agencies for comparison. Additionally, agencies can run reports of particular interest to them. The OHV and the NFP program have data sharing agreements in place that allows for regular data downloads that are sent to the OHV. This agreement allows the OHV incorporate NFP data into the state level home visiting reports.

Healthy Families America

The HFA program in Ogden began implementation in 2008 and has been operating full caseloads for the past three years. The program was funded for an additional assessment worker in 2010,

through a grant from the OHV, to manage the large number of referrals they were receiving from community partners.

HFA programs use a unique strategy called "creative outreach" to minimize client attrition rates. Creative outreach allows staff to continue to creatively reach out to families for three months-even if they are not at home for scheduled visits-knowing that families served by HFA often have not had solid trusting relationships. Programs are required to complete a program acceptance analysis and a family retention analysis at least every two years to identify patterns and trends, and then develop plans to improve retention.

Parents as Teachers
PAT is designed to serve families throughout pregnancy until their children enter kindergarten. Targeted recruitment of participants is completed by the local program site, and is influenced by the type of community and its associated characteristics. While PAT has universal eligibility, the goals of the OHV and the UPAT program are to support and improve maternal and early childhood outcomes, which include pregnancy and birth outcomes. Subsequently, the PAT program will target pregnant women through the MIECHVP program funding.

The PAT National Office recommends that in the first year a home visitor provide a maximum of 48 home visits a month, depending on how intensively the services are being delivered and how much time is needed for travel, etc. The PAT program site has significant numbers of identified, eligible families on waiting lists and a strong partnership with NFP, so the timeline for achieving maximum caseload will be short. The OHV anticipates that the PAT program will meet full caseload within 6 months after the hiring and training of a new home visitor.

The PAT model is not designed to meet every need for families. Rather, sites develop partnerships that support referrals for families and improve coordination with schools, local early childhood councils, government programs (such as WIC, Medicaid, CHIP, Child Find), libraries, the business sector, and community and faith-based organizations to provide a powerful network of support for families. As described in an earlier section of this document, PAT established a referral partnership with NFP to serve those on their waiting list or who are ineligible for the NFP program. The UPAT Director participates in the monthly collaborative meetings that include NFP, EHS and other non-evidence based programs. Community advisory councils are now required of PAT affiliate programs.

PAT National Office provides a fee-based data management system called Visit Tracker. Visit Tracker is a web-based family contact management, recordkeeping and service delivery tracking system. Visit Tracker maximizes program effectiveness by providing real-time access to reports that support program management, model fidelity monitoring and CQI activities. Parent educators and supervisors can access visit records and plan upcoming visits with families, monitor quality and track model fidelity. PAT is working to ensure all of the benchmarks and constructs required under the MIECHVP can be tracked through this system. Utah's PAT affiliates are currently using Visit Tracker, but through an OHV/PAT data sharing agreement with PAT, the OHV will have access to PAT program data to capture relevant information for the MIECHVP. The OHV's data base contractors will phase in the data requirements for the PAT programs so that they can eventually discontinue use of the Visit Tracker.

Utah's Plan for Working with the National Model Developers

The OHV has working relationships with the Western Region liaison for HFA and NFP. To date, these relationships have been strong and collaborative in nature. PAT has a nationally supported state office in Utah which works closely with the OHV and is part of its Steering Committee. Preliminary approval letters supporting program implementation/expansion were submitted to HRSA from NFP, HFA and PAT national offices. Delineation of roles for the model developer and the OHV are presented previously in Table 5.

OHV staff met with Blanche Brunk, the western region liaison from the NFP/NSO during her annual site visit to the Salt Lake Valley Health Department's NFP program. The OHV shared the potential plan to expand the NFP program but at least two home visitors. The final plan was emailed to Ms. Brunk upon completion.

OHV staff had phone and email correspondence with Kate Whitaker, the HFA liaison to Utah to discuss the potential state plan for expanding the HFA program in Weber County. The final plan was also sent to Ms. Whitaker upon completion. Additional conversations were had to discuss the possibility of implementation of a HFA program in Washington County through FY11 funding. The OHV received a letter of approval from HFA National indicating their support for an additional program. The final plan will be sent to Ms. Whitaker upon completion.

OHV staff met with the Utah Parents as Teachers director Meg Miles, as well as, Karen Guskin from the PAT National Office to share with them our potential plans for expanding both the program in Salt Lake County and in Uintah County. The final plan was shared with them upon completion. Additional conversations were had with Meg Miles to discuss the potential implementation of the PAT program in Carbon and/or Washington counties with FY11 funds. An email exchange occurred with Karen Guskin from PAT National who then provided the OHV with a letter of support. The final plan will be sent to Ms. Miles and Ms. Guskin upon completion.

The OHV will maintain the relationships it has with the national model developers to support program implementation at the local level.

Description of Technical Assistance Provided by the NFP, HFA and PAT Model Developers

Nurse Family Partnership

The NFP NSO has developed several steps that a community and organization must take before implementing the model. First is providing orientation to the program model and its implementation requirements. This is to ensure that those considering adopting NFP have a thorough understanding of the home visiting intervention and what contributes to a successful program operation and good outcomes. Commitment to implementing the model elements, with the support of the national office, is a contractual requirement of each entity implementing the program. Second, prior to implementing a program in a community, the NFP NSO engages a range of community residents to educate them about the NFP program and assist them in conducting feasibility testing to determine whether the program will meet their needs. The third step involves selection of an implementing agency. The NSO provides assistance in selecting a local agency and

offers help developing an implementation plan. Lastly, support for the education and training of home visiting program staff. Education topics include: staff recruitment, staff competency definitions, assessments, home visitor and supervisor education process, and diversity and cultural competency.

Additional support and technical assistance provided by the NFP NSO include: clinical support, evaluation and monitoring for the program, nurse practice support and training; clinical and programmatic technical assistance, compliance monitoring and support; program development and implementation support, and performance improvement monitoring and support.

Healthy Families America
HFA National Office provides training, technical assistance and quality assurance support to individual sites in local communities, while also assisting state systems in building their own infrastructures for in-state advocacy, funding, training and evaluation. As part of the HFA accreditation process each local site develops a Self Study which provides the program with an opportunity for internal review of its service delivery and administration against professionally accepted, consensus and research-based national standards. Following the Self Study, a 2-4 day site visit provides a review of this self analysis which is rated by HFA staff and peer reviewers. The ratings provide an assessment in quantitative terms of the 160 standards outlined in the HFA Self Assessment Tool. In addition, technical assistance is provided via phone or email as well as on-site technical assistance visits for a fee (separate from the accreditation visits) specifically designed to local needs. Utah has three HFA programs that receive ongoing support from the HFA regional office.

Parents as Teachers
The PAT national office provides the following training and technical assistance, as appropriate, for organizations implementing the PAT model:

- Start-up Guidance
- Foundational and Model Implementation Training
- Annual Conference
- State Office Support
- Annual Recertification

Describe Types of Initial and Ongoing Training and Professional Development Activities Provided by the State and/or the National Model Developers
The OHV recognizes the importance of ongoing training and technical assistance to assure high levels of fidelity and quality of programming. Begun under the EBHV grant, the OHV convened an ad hoc group to develop recommendations for the development of a coordinated training system for home visiting programs and other early childhood professionals. OHV staff developed a professional development survey, which was sent out electronically, to understand the training needs of programs. The OHV plans to periodically survey staff in home visiting and other early childhood programs for input on the types of training they need and/or want in order to offer relevant training opportunities. As part of its systems building efforts, the OHV collaborates with other early childhood programs at the state and community level to offer training opportunities to home visiting and early childhood professionals. The OHV currently contracts with Utah PAT to

support the provision of training opportunities. Due to EBHV funding changes and the OHV's focus on the MIECHV application, the professional development work group has not met since the end of 2010. However, meetings will restart in January 2012. Committee membership consists of representatives from the Office of Child Care, Part C Early Intervention, Utah State University, Child Care Resource and Referral and Head Start State Collaboration office. An ongoing meeting schedule will be established at the January meeting.

Initial or core training is provided by the national office of NFP, HFA, and PAT. Each program has a week-long, or longer, core training session that is required.

Nurse Family Partnership
NFP provides face-to-face and distance learning opportunities for the Core Education Training required for all NFP nurses and supervisors. The NFP National Service Office (NSO) also provides ongoing support and training through Dedicated Nursing Practice Consultants that work closely with each individual implementing agency to provide ongoing assistance and guidance.

Healthy Families America
HFA provides model specific Core Training for all direct service staff and their supervisors within six months of hire. HFA Core Training covers identifying families at risk, completing standardized risk assessments, offering services and making referrals, promoting use of preventive health care services, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, and managing crisis situations. In addition to the core training, supervisors or program managers of HFA direct staff must attend a three day intensive in-person training that covers topics such as: types of supervision, quality management techniques, crisis management, case management and reflective practice.

Parents as Teachers
PAT Affiliate programs must send all home visitors and supervisors to the PAT Foundational Training and the Model Implementation Training. The Foundational Training lays the foundation for home visiting as a methodology within the early childhood system and connects the theoretical framework of PAT with practice. Model Implementation Training incorporates the PAT Quality Assurance Guidelines and offers implementation strategies and evidence-based practices that help affiliate organizations fully understand and bring to life quality PAT services. The training explains how to successfully replicate the PAT model with fidelity. Demonstrating accountability, evaluation and outcomes are themes woven throughout. PAT requires that home visitors access competency-based professional development and training and recertify with the national office annually. Additionally, each PAT supervisor must work with each home visitor to help them develop a professional growth plan using the PAT core competencies as a framework. Annually, home visitors and their supervisors should re-assess their competencies and use this assessment to develop written professional development goals. In this way, specific training opportunities or professional growth opportunities can be identified to meet these goals.

Ongoing PAT professional development may be obtained through the PAT national office or through other approved avenues. The OHV partners with the State PAT Office to offer professional

development training to the home visiting community. A recent example of this was the PAT training on working with teen parents. The OHV provided funding for this training so that all home visitors, regardless of program model or level of evidence, could attend.

Additional training information

To address the changing demographics of the state, the OHV will provide annual training on cultural competency, through partnerships with the Utah Department of Health, Office of Minority Health, the Asian Association of Utah which works closely with the state's refugee population, Melissa Zito (UDOH liaison to the Native American communities), the Indian Walk-in Center, and the Center for Health Disparities Reduction.

Recognizing the importance of adhering to the research-based curriculum associated with each program, the OHV will work closely with the local home visiting program and the corresponding model developer to explore the need for an adaptation of the curriculum to meet the needs of a particular minority. Subcontractors are required to hire professionals that meet the cultural and linguistic needs of their target populations which means, at a minimum, local home visiting programs must hire staff that speak a language other than English, and/or from racial/ethnic groups that represent the families participating in the home visiting program. The cultural competency trainings mentioned in the above paragraph can help the home visitors modify the delivery of the program to meet the individualized needs of the program participants.

The State Home Visiting Program's Role in Monitoring Fidelity and Program Quality

The OHV will partner with the national model developers and local home visiting agencies to support quality implementation, offer technical assistance that supplements what is offered by the national programs, monitor program activity, provide quarterly and annual and quarterly updates, and contractually obligate programs to adhere to model fidelity requirements.

In addition to working with the National Programs, OHV will work with each individual program to monitor program fidelity.

The OHV will support adherence to model fidelity of implementing agencies by:

- Requiring a contract and program plan (see subcontract language in the section below).
- Requiring commitment to consistent documentation of service process data and use of these data to guide continuous program improvement;
- Providing technical assistance to implementing agencies through site visits, teleconferences, webinars, and one-on-one phone calls.
- Conducting a minimum of two site visits annually with one visit to include OHV staff shadowing a home visitor. Written feedback that will include recommendations and timelines will be provided to sites within two weeks of visit.
- Collecting and assessing quarterly reports on process and outcome data. Feedback will be provided to individual sites on the status of their data quality and performance.
- Monitoring and analyzing data related to benchmarks and programs status on benchmark attainment.
- Monitoring and analyzing data to ensure fidelity to the model and to provide a feedback loop for continuous quality improvement.

- Monitoring the state home visiting database, quarterly, for data quality and consistency.

The OHV will spend the next several months developing a site visit review tool to provide consistency in the way visits are conducted so that program fidelity is appropriately and consistently monitored.

The OHV will develop an MOU with the model developers to provide an annual verification that programs are in compliance with their national model. Part of this agreement will detail how the OHV will partner with the model developers to support them in providing technical assistance and support when it is necessary.

In 2010, the OHV conducted key informant interviews with all evidence-based home visiting programs that included the agency director, program supervisor, and a home visitor. The interviews provided an opportunity to learn about challenges, needs and successes of the programs and how the OHV staff might provide support and respond to issues associated with the implementation of the program. The OHV plans to conduct these interviews annually and to add parent input through key informant interview or surveys. Key informant interviews not only supply the OHV with important information about the programs to support fidelity and quality but they also act as a form of continuous quality improvement for the OHV.

Implementing agencies will be trained in Continuous Quality Improvement methods, how to use their data, to not only improve quality to monitor program implementation.

Utah's Plan for Obtaining or Modifying Data Systems for Ongoing Continuous Quality Improvement

In early 2010, the OHV contracted with a data base company to design and build a state home visiting data base to collect, track, and report process, outcome, and fidelity data. The database currently serves Utah's HFA programs however the database developers are working toward incorporating the data needs of the PAT programs. At present, PAT programs are using the PAT Visit Tracker program. The OHV is working closely with the developers on a plan and timeline to modify the database to meet the needs of PAT programs and collection of the mandated benchmarks. The NFP NSO provides affiliate programs with its own proprietary Efforts to Outcomes (ETO) information system and continuously monitors the data from local programs. The OHV maintains a data sharing agreement with the NFP program for regular data downloads; this will continue throughout the project.

The OHV evaluator is responsible for training programs on CQI methodology, implementation, and the ongoing benefits it provides for implementation fidelity and improving program quality. To date, the OHV evaluator has conducted two on-site meetings with home visiting staff to present on the use of CQI. The evaluator will meet with all MIECHV funded programs within six months of program implementation. Programs that will newly implement Healthy Families America will receive training on the use of the state home visiting database within the first month of implementation.

While the NFP NSO works closely with the Salt Lake Valley Health Department (SLVHD) to ensure the program is in compliance with model fidelity-related elements, they also closely monitor other

aspects of program implementation, providing summary reports and data that the local site can use to improve its work. In fact, the NFP supervisor in the SLVHD is able to run a number of different summary reports which are helpful in understanding and improving the way the NFP is implemented locally. Further, the OHV also has a data sharing agreement with the NFP NSO which provides access to a uniform list of data elements needed for the local evaluation. These data sets are sent from the NFP NSO to the SLVHD which then passes the data to the OHV evaluation staff. Similar to the monitoring structure of the NFP Program with its own information system, the OHV will determine a periodicity schedule for reviewing agency level fidelity data. These data will be fed back to the implementing agencies through data reports, phone calls and site visits. Each agency will be able to access its own data for the purposes of quality improvement

Plan for subcontracting

The OHV intends to award subcontracts to community-based organizations to implement evidence-based home visiting programs. The OHV has obtained the Utah State Division of Purchasing approval to develop "Sole Source" contracts with agencies in Salt Lake, Weber and Uintah counties. This enables the OHV to contract with the program's host agency directly without going through a public Request for Proposal process. These agencies have already been implementing the home visiting models under this sole source agreement and have worked extensively with the OHV.

Interested organizations in Carbon and Washington counties will apply for FY 11 MIECHV funds through a RFP process. OHV staff has written the RFPs and is waiting for the appropriate approval process to be completed. Once approval has been given the RFP will be put out to public. Applicants have 60 days to respond. The OHV anticipates completion of the RFP process with a contract award(s) in place by February 2012. Copies of the OHV application and RFP are attached to this document.

Anticipated Challenges to Fidelity

Client attrition is one of the biggest challenges that face the home visiting programs. All funded programs will be required to submit attrition plans to address this concern. OHV will monitor attrition through the database and discussions with program directors. OHV will provide training on supporting the most vulnerable families. OHV will provide other training and technical assistance as the specific needs arise.

Due to the rural nature of Carbon and Uintah counties there may be challenges related to participant recruitment and adequacy of community resources. The OHV will work closely with these communities to address the challenges that may arise. The OHV will be providing monthly site visits through the first six months of implementation, and provide ongoing technical assistance related to implementation.

An anticipated challenge for the OHV is the quality and completeness of the data to evaluate fidelity. To minimize this challenge the OHV evaluator provides technical assistance related to data entry and any problems associated with timely and accurate data entry. In addition, he will provide agency specific technical assistance on the benefits of accurate data to the agency, such as quality improvement and evaluation.

A potential challenge facing local implementing agencies is the utilization of a continuous quality improvement process. The capacity of these small agencies limits local expertise for data analysis that will be helpful to the CQI process. Local staff is able to run basic summary reports that are set up in the database in accordance with the model-specific requirements. However, they don't have the ability to conduct more detailed analysis which would likely make a more significant contribution to understanding program implementation effectiveness.

The OHV will address this challenge by providing technical assistance to each implementing site based on their specific need. OHV staff can conduct statistical analysis that would lead to the creation of helpful graphs and charts that summarize various aspects of home visiting data and service delivery outcomes that can be used by the local programs. The OHV staff sees this technical assistance role diminishing over time as the local staff learns how to perform these data analyses.

Collaborative Partners:

Department of Health, Title V	Department of Workforce Services, TANF	Department of Workforce Services, Office of Child Care
Head Start State Collaboration Office	Department of Human Services Division of Child and Family Services	Part C Early Intervention
Healthy Families Utah	Utah Parents as Teachers	Nurse Family Partnership
Utah State University, Early Intervention Research Institute	Local Health Departments	Association of Family Support Centers
Voices for Utah Children	Utah State Office of Education, Title I	Head Start Association Directors
United Ways of Utah	Department of Human Services, Division of Substance Abuse and Mental Health	Asian Association of Utah
Department of Health, Violence and Injury Prevention	University of Utah Department of Pediatrics	University of Utah , Social Research Institute

Utah provides assurances that:

- The State home visiting program is designed to result in participant outcomes noted in the legislation;
- Individualized assessments will be conducted or participant families and that service will be provided in accordance with the assessments;
- Services will be voluntary;
- Priority will be given to service eligible participants who:
    - Are low income
    - Are pregnant and under 21
    - Have a history of child abuse or neglect or have had interactions with child welfare services
    - Have a history of substance abuse or need substance abuse treatment
    - Are users of tobacco products in the home
    - Have, or have children with, low student achievement
    - Have children with developmental delays or disabilities
    - Are in families that include individuals who are serving or have formerly served in the armed forces.

Plan for coordination between the proposed home visiting programs and other existing programs and resources in the communities.

The purpose of establishing an early childhood system of care is to improve coordination of services, align referral processes, and improve knowledge of and access to community resources; this establishes a local system that ensures inclusion of home visiting into the local early childhood system.

At the state level, the ECCS grant administrator is in the process of developing a state early childhood plan. OHV staff is a member of the ECCS committee and participates in the planning process. As this plan coalesces, the OHV will promote the plan to local communities with home visiting programs in terms of how it applies to a local community, and how home visiting plays a key role in the early childhood system services. State and local partners will be necessary for integration to occur.

While there is no formal early childhood system at the state or local level at this time, some communities do have existing early childhood councils or groups of early childhood providers that meet with some regularity. One example of this is the Healthy Moms Coalition in Weber County mentioned in Section Three. Salt Lake County is the only county receiving funds through the MIECHV program that has an existing early childhood council. There is no existing early childhood council in Uintah, but the Northeastern Counseling Center, located in the County, hosts monthly meetings to facilitate cross-agency sharing. Through the application and RFP processes, each applicant is asked to detail a plan for coordinating their program with existing program in their community. The OHV will take a leadership role in facilitating local home visiting programs to integrate into existing "systems" through technical assistance, for example, facilitating introductions to community partners, educating the community about home visiting and the importance of collaboration to maximize service delivery to families and attending existing coordinating meetings. The OHV will monitor coordination and collaboration activities through subcontract reporting and site visits. Technical assistance will be provided to home visiting programs if participation in the council or coalition is not occurring as contracted. A written plan, with timeline, will be provided for local agencies to monitor ongoing compliance.

Salt Lake County Nurse Family Partnership
As previously discussed in this document, NFP and the other home visiting programs in Salt Lake County have begun monthly partnership meetings to promote and enhance their coordination for identifying and referring families as well as for building partnerships with programs that serve as social supports for home visiting clients. The NFP NSO also requires local programs to have a community advisory board that represents the community and its stakeholders. NFP has coordinated with several programs in the community that have brought strength to the overall program and needed support to its clients. The NFP supervisor developed a Memorandum of Understanding (MOU) with the County Housing Authority regarding the Housing Assistance and Recovery Program (HARP). The MOU states that the County Housing Authority will set aside six of its housing slots for families in the NFP program that are at risk of becoming homeless. The NFP supervisor has also done outreach to the high schools in the county that have programs for pregnant teens. While there is no MOU in place, an agreement was developed with one high school granting a pregnant student course credit towards graduation for participating in the NFP program.

Additionally, Salt Lake County Substance Abuse Program provides for one of its substance abuse social workers to provide 1-to-1 case consultation to the nurses and occasionally will accompany a nurse on a home visit. The NFP program has done an excellent job of connecting with community resources for the benefit of the program and its families. The OHV has called upon NFP to speak at the OHV Advisory Committee meetings on the success of their collaboration activities.

The Salt Lake NFP program currently has formal agreements with a variety of other agencies. While the program supervisor has established personal contacts with community agencies which help to better access resources, the nurses frequently initiate contact with service providers in behalf of their client families. If a family experiences a severe crisis, or has an unusually difficult set of challenges, the nurse shares the situation with the supervisor and other members of the NFP nursing team in their weekly team meeting so that the best possible solution to the family's need can be achieved. Given the extensive array of human service providers in Salt Lake County, it is not uncommon to have families linked with several of the following resources simultaneously. Some of the referral resources that are routinely used include: Salt Lake Valley Health Department's car seat program and Children with Special Health Care Needs, Division of Child and Family Service, County Housing Authority, local school districts and alternative schools, Early Head Start, Early Intervention, Youth Employability Services and the Family Support Center. The nurses also work closely with the client's medical providers to assure optimum health.

Salt Lake and Uintah Counties Parents as Teachers
Parent educators work closely with their individual families and assist them in linking with the community agencies that provide the specific services needed. A tool used by the PAT program that facilitates this client needs assessment is the community resource survey. The survey will assess the needs of the family and the level of assistance needed and available. When possible an MOU between Utah PAT and the community partner will be developed as follows:

Level I: Client resource referral partner
Level II: Program Consultant partner
Level III: Key Stakeholder partner

A community resource referral list will be used by parent educators to refer families to appropriate community services. The list will be compiled and used by the supervisor and/or parent educators for specific client needs. Agencies that have particular investment in home visiting policies and promotion will be invited to sit on the UPAT advisory committee. It is anticipated that agencies may be working on multiple levels with UPAT simultaneously. The following agencies are organizations that Utah PAT Salt Lake County and Vernal programs will use as a resource.

Salt Lake County:

- Part C Early Intervention program
- Nurse Family Partnership
- Salt Lake School District
- Salt Lake County Housing Authority
- Salt Lake Community Action Program and Head Start
- The Road Home Homeless Shelter
- Her Nero Moo Center for Immigrants

- Salt Lake County Health Clinic
- Area Hospitals
- OB/GYN doctors
- The Children's Center
- Optum Mental Health
- Salt Lake County Division of Substance Abuse
- Cornerstone Counseling Center
- Youth Support Services
- YWCA Domestic Violence Shelter

Uintah County

- Part C Early Intervention program
- Little Blossom Child Care
- Uintah School District-specialized preschool program
- Head Start
- Local pediatricians
- Ashley Valley Medical Center
- Uintah Basin Medical Center
- Tri-County Health Department (Medical Clinic & WIC)
- Substance Abuse Recovery Program
- Turning Point Domestic Violence Shelter
- The Children's Justice Center
- Division of Child and Family Services

Weber County Healthy Families America

The approach that the HFA program takes recognizes that most families would benefit from a well organized network of services that includes mental health, substance abuse, domestic violence prevention, and child care. In Weber County there are various coalitions already in place, which focus their combined efforts on meeting the needs of parents. Section Three of this document provides a detailed description of The "Healthy Moms" coalition created for the purpose of serving Healthy Families Utah as a community partner for referrals, and as an advisory board. The coalition also collaborates to better serve the community by providing a network base that directs families to the appropriate resources that will best meet their particular needs. The Healthy Mom's Coalition meets every month to coordinate existing community services and explore the development of new programs depending on the needs of the community.

The OHV will take a leadership role in fostering statewide collaboration by using the OHV Steering Committee meetings as a venue for on-going dialog about improving interagency cooperation. Since the committee is comprised of representatives of state agencies such as the Division of Substance Abuse and Mental Health, DCFS, and the DOH, the regular meetings provide an opportunity for group discussions and brainstorming between these key partners. Through this process, practical solutions can be proposed and consensus developed as the committee marshals its resources to try and improve collaboration on a number of fronts. Similarly, the OHV Steering Committee can also serve as a resource directly to each home visiting program. For example, as the local programs develop their own community advisory boards, the OHV Steering Committee may be

able to offer training and technical assistance to support the growth and development of the local board, particularly as each one deals with issues related to improving local interagency networking and collaboration.

Washington and Carbon counties will discuss the coordination of the home visiting program with other resources in the community in their RFP response.

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

Home visiting programs in Utah to date have primarily addressed issues related to improving maternal and child health, improving parenting practices, and preventing child abuse since these areas were the focus of the EBHV grant. This revised plan includes the establishment of comprehensive benchmarks for each of the required MIECHV program goals. The six legislatively-mandated benchmark areas to be addressed are:

- Improved maternal and newborn health;
- Prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits;
- Improvement in school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvements in family economic self-sufficiency; and ,
- Improvements in the coordination and referrals for other community resources and supports.

The establishment of state benchmarks for these home visiting programs will help the OHV mesh the requirements for accountability with efforts to build a continuous quality improvement system, which over time will contribute to both effective and improved home visiting programs. The format used to present the legislatively-mandated benchmarks in Utah will include a table for each of the six benchmark areas. Each table will include the required constructs, the definitions we propose for those constructs, and the expected outcome we anticipate. Following the benchmark tables, a description of each measure including the known reliability and validity are provided. Data collection periodicity will also be specified within the table for each construct.

The quantifiable improvement measures Utah has selected have specific directionality in most cases. For example, many seek measurable percentage increases for outcome measures such as prenatal care for the mother or well-child visits for the baby. Other objectives focus on percentage decreases for such things as tobacco use and visits to the emergency department. Several of the constructs in the Utah plan focus on process measures of which a few have specified "increase or *maintain"* in the definition. The reason Utah has included "*maintain"* in its goal is due to the high ceiling effect that is likely to be found with various constructs. In other words, the data collection is not likely to detect an increase between the initial and second data collection point. As an example, one construct focuses on providing information to the mother about 4 specific child safety topics. Based

on information from the home visiting programs it is believed a high percent of mothers receive this information so a reasonable goal would be to maintain this level of compliance.

The OHV also requires those receiving the MIECHV funding to collect other critical data at intake and during subsequent home visits. Participant-level data are usually descriptive in nature, such as demographic and service utilization data. Most of these data elements are contained in the Client File and are collected by the home visitors during interviews with the program participants. Examples of these variables include: gender of the baby, age of the mother, birth father, or other primary care-giver; racial and ethnic background of the immediate family; parent's language, income, and socioeconomic status, and educational achievement. The Client File also serves as the repository for hard copies of the formal assessment tools used by the home visitors. These include screening assessments completed both by the parent (self-administered), and the home visitor (observation).

Other information that is gathered more frequently during the home visits through an interview focuses on service delivery variables such as home visits scheduled / completed and length and location of the home visit. These data elements are part of the Home Visit Record, which includes the content /topical information provided during the visit such as percentage of time spent on child development, parent-child interaction, health care, family functioning, family environmental needs, and administrative issues. The record also provides a place to document referrals made by the home visitors to the family, as well as case notes.

Administrative data are data collected by each of the home visiting implementing agencies. This data documents the formal established relationships (via Memorandums of Understanding) between the home visiting programs and their partner agencies at the community-level. In addition to documenting the changes in the number of formal agreements between agencies, the implementing agencies will also track the number of agencies with whom they share information.

Benchmark 1: Improved Maternal and Newborn Health

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(i) Prenatal Care	Pregnant Women	% of pregnant women enrolled in HFA, NFP, or PAT who have a medical provider 6 weeks after intake that did not at enrollment	# of pregnant women in HFA, NFP, or PAT who do not have a medical provider at intake but do at 6 week follow-up	# of pregnant women enrolled in HFA, NFP or PAT who do not have a medical provider at intake	Increase % pregnant women receiving prenatal care within 6 weeks after intake	Interview (home visit record) SLVHD (NFP) to use checklist with date in client file See questions in attached table	Outcome measure for % of pregnant women who have a medical provider. Comparison will be within cohort.	HP 2010 goal is for 90% to receive prenatal care in 1st trimester. However, in Utah approx. 30% do not receive prenatal care in 1st trimester. The implementing agencies report uninsured and Medicaid eligible women.
(ii) Parental use of alcohol, tobacco or illicit drugs*	Women	% of women enrolled in HFA, NFP, or PAT using tobacco	# of women enrolled in HFA, NFP, or PAT who use tobacco at intake and one year post-partum	# of women enrolled in HFA, NFP, or PAT who use tobacco at intake	Decrease % of women enrolled in HFA, PAT, or NFP using tobacco from intake to one year post-partum	Interview (home visit record) See questions in attached table	Outcome measure of % change of tobacco use from intake to one year post-partum. Comparison will be within cohort.	Utah chose to focus on tobacco According to recent PRAMS data, 9.6 percent of women under 17 yrs. and 12% of those 18-19 yrs. smoked in the 3rd trimester, Although implementing agencies report low tobacco use among clients, these programs serve younger women generally which supports the focus on tobacco.
(iii) Preconception care	Women	% of women enrolled in HFA, NFP or PAT who receive one routine primary care visit within 6 months post partum	# of women enrolled in HFA, NFP, or PAT who receive one routine primary care visit within 6 months post partum	# women of who have been enrolled in HFA, NFP, or PAT who are 6 months post partum	Increase % women receiving routine primary care visit within 6 months post partum	Interview (home visit record) SLVHD (NFP) to use checklist with date in client file See questions in attached table	Outcome measure of women receiving one routine primary care visit within 6 months post partum. Comparison will be between Cohort 1 and Cohort 2.	Only 25% of women in Utah report visiting with their health care provider to prepare for a healthy pregnancy.

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(iv) Inter-birth intervals	Women	% of women enrolled in HFA, NFP, or PAT who receive information about optimal birth spacing within 6 months post partum	# of women enrolled in HFA, NFP, or PAT who receive information about optimal birth spacing within 6 months post partum	# of women enrolled in HFA, NFP, or PAT who are 6 months post partum	Increase or maintain % of women receiving information about optimal birth spacing from enrollment within 6 months post partum	Interview (home visit record) SLVHD (NFP) to use checklist with date in client file	Process measure to increase or maintain the # of women receiving optimal birth spacing information within 6 months post partum. Comparison will be between Cohort 1 and Cohort 2.	HP 2010 goal is for no more than 6% of births occurring within 24 mo. of previous pregnancy. In Utah 21% of repeat births were conceived within 15 mo. of last live birth
(v) Screening for maternal depressive symptoms	Women	% of women enrolled in HFA, NFP, or PAT who are screened for maternal depression	# of women enrolled in HFA, NFP, or PAT who are screened for depression at infancy 1-4 weeks	# women enrolled in HFA, NFP, or PAT who are 4 weeks postpartum	Increase % of women screened for maternal depression at infancy 1-4 weeks	Screening with Edinburgh Postnatal Depression Scale (Client file)	Process measure of women screened for depression. Comparison between Cohort 1 and Cohort 2.	The rate of self-reported postpartum depression in Utah women was 13%. Only 38% of these women sought help from a healthcare provider.
(vi) Breastfeeding	Mothers	% of mothers enrolled prenatally in HFA, NFP, or PAT who breastfeed their child for at least 2 weeks	# of mothers enrolled prenatally in HFA, NFP, or PAT who breastfeed their child for at least 2 weeks	# mothers enrolled prenatally in HFA, NFP, or PAT and are at least 2 weeks post partum	Increase % of mothers who breastfeed for at least 2 weeks	Interview (home visit record) See attached questions.	Outcome measure of the % of mothers who breastfeed at birth for at least 2 weeks. Comparison will be between Cohort 1 and Cohort 2.	Defined as any combination of breastfeeding and formula supplementation. Only 66 % of women in Utah breastfeed at 4 months with 48% maintaining the practice at 6 months. According to other PRAMS data, younger women breastfeed at even lower levels.
(vii) Well-child visits	Children	% of children receiving at least one recommended well-child visit by 6 months.	# of children enrolled in HFA, NFP or PAT receiving at least one recommended well-child visit by 6 months	#children enrolled in HFA, NFP, or PAT who are 6 months or older by reporting time	Increase % of children receiving at least one recommended well-child visit by 6 months	Interview (home visit record)	Outcome measure of % of children receiving recommended well-child visits by 6 months. Comparison will be between Cohort 1 and Cohort 2.	Must receive at least 1 by 6 months. Utah has one of the highest rates of early infant discharge coupled with the lowest rate of infant follow up (20%) within the first week of discharge.

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(viii)Maternal and child health insurance status	Children and women (enrolled prenatally)	% of children and women (enrolled prenatally) in HFA, NFP, or PAT who obtain medical/health insurance coverage	# of children and women enrolled in HFA, NFP, or PAT who have medical/health insurance coverage 3 months after enrollment that did not at enrollment	# of children and women enrolled in HFA, NFP, or PAT who did not have medical/health insurance coverage at enrollment.	Increase % of children and women enrolled in HFA, NFP, or PAT who have medical/health insurance coverage	Interview (home visit record) SLVHD (NFP) to use checklist with date in client file See attached questions.	Outcome measure to increase % of children and women with insurance at 3 months after enrollment Comparison will be within cohorts.	If mother enrolls prenatally birth of child will be considered the beginning measure of this construct 17% of women of reproductive age in Utah are uninsured

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(i) Visits for children to the emergency department from all causes	Children	# of ED visits by children enrolled in HFA, NFP or PAT for all causes			Decrease # of ED visits of children from the first 6 months of enrollment to the second six months of enrollment	Interview (home visit record) See attached questions.	Outcome measure of # of ED visits by children enrolled in the program. Comparison will be within cohort and the comparison will be the first 6 months vs. the second 6 months.	Home visitors to ask at 6 & 12 months (age of the baby) Utah will define Emergency Department as Emergency Department and Urgent Care facilities.
(ii) Visits of mothers to the emergency department from all causes	Mothers	# of ED visits by mothers enrolled in HFA, NFP, or PAT for all causes			Decrease # visits to the ED by mothers from the first 6 months of enrollment to the second six months of enrollment	Interview (home visit record) See attached questions.	Outcome measure of # of ED visits by mothers enrolled in the program. Comparison will be within cohort and the comparison will be the first 6 months vs. the second 6 months.	Home visitors to ask at 6 & 12 months (age of the baby) Utah will define Emergency Department as Emergency Department and Urgent Care facilities.
(iii) Information provided or training of participants on prevention of child injuries.	Mothers	% of mothers receiving information or training on injury prevention. All 4 topics must be completed by 6 months postpartum.	# of mothers receiving information or training on injury prevention by 6 months postpartum	# of mothers enrolled for at least 6 months post partum in HFA, NFP, or PAT	Increase % of mothers receiving information or training on injury prevention after one year	Interview (home visit record)	Process measure of % of clients who received information or training on injury prevention. Comparison will be between Cohort 1 and Cohort 2.	Information or training will cover topics including: safe sleep, shaken baby, passenger safety, and home safety. Data collected at 6 months based on the child's age.
(iv) Incidence of child injuries requiring medical treatment	Children	# of child injuries requiring medical treatment			Decreases the # of incidences of injuries requiring medical treatment in children enrolled in home visiting services	Interview (home visit record) See attached questions.	Outcome measure of # of incidences of injuries requiring medical treatment in infants /children. Comparison will be between Cohort 1 and Cohort 2.	Home visitors to ask at 6 & 12 months (age of the baby)

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(v) Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)	Children	% of suspected child maltreatment cases of children enrolled in HFA, NFP, or PAT	# of suspected child maltreatment cases of children enrolled in HFA, NFP, or PAT	# of children of enrolled in HFA, NFP, or PAT	Decrease or maintain % of children who were suspected maltreatment victims from year 1 to year 2 in the 0 - 12 month age category	The OHV will work with local & state child welfare system for verification.	Outcome measure of % of suspected cases of maltreatment of children in the program. Comparison will be between Cohort 1 and Cohort 2.	Utah does not report "suspected child maltreatment", however, the OHV is e collaborating with Division of Child and Family Services to find an alternative measure for this construct.
(vi) Reported substantiated maltreatment (substantiated/ indicated /alternative response victim) for children in the program	Children	% of substantiated child maltreatment cases of children enrolled in HFA, NFP, or PAT	# of substantiated child maltreatment cases of children enrolled in HFA, NFP, or PAT	# of children of enrolled in HFA, NFP, or PAT	Decrease or maintain % of children who were substantiated maltreatment victims from year 1 to year 2 in the 0-12 month age category	The OHV will work with local & state child welfare system for verification.	Outcome measure of % of substantiated cases of maltreatment of children in the program. Comparison will be between Cohort 1 and Cohort 2.	In Utah "substantiated" is defined as "supported" child maltreatment cases
(vii) First-time victims of maltreatment for children in the program **Note: First-time victim defined as had a maltreatment disposition of "victim" & never had a prior disposition of victim.**	Children	% of children enrolled in HFA, NFP or PAT who are first-time victims of maltreatment	# of children enrolled in HFA, NFP or PAT who are first-time victims of maltreatment	# of children enrolled in HFA, NFP or PAT	Decrease or maintain % children enrolled in HFA, NFP or PAT who are first-time victims of child maltreatment in the 0 -12 month age category	The OHV will work with local & state child welfare system for verification.	Outcome measure of % of children in the program who are first-time victims. Comparison will be between Cohort 1 and Cohort 2.	

* In Utah official CPS records are accessed only by Division of Child and Family Services employees. They will only confirm whether or not the names furnished them by the OHV (with % of children) are in the database.

Benchmark 3: Improvements in School Readiness

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(i) Parent support for children's learning & development (e.g., appropriate toys available; read & talk with child)	Mothers	% of mothers enrolled in HFA, NFP, and PAT who increase their score on the HOME construct: Learning materials and Involvement between the 6 and 18 month assessment	#of mothers enrolled in HFA, NFP, and PAT who increase their score on the HOME construct: Learning materials and Involvement between the 6 and 18 month assessment	# of mothers enrolled in HFA, NFP, and PAT who complete both the 6 and 18 month assessment	Increase the score on HOME constructs: Learning materials and Involvement between 6 and 18 months assessment	Tested with HOME Client File	Outcome measure of % of mothers who maintain or increase score on the HOME from 6 months to 18 months. Comparison will be within cohorts.	Test will be given at 6 and 12 months. Scale scores calculated for individual scales based on protocol of measure developer. Score from 6 mo. assessment compared to 18 mo. assessment.
(ii)Parent knowledge of child development & of their child's developmental progress	Mothers	% of mothers enrolled in HFA, NFP, and PAT who receive information about their child's learning and development from a standardized screening tool (ASQ 3) by the 6 month assessment	# of mothers enrolled in HFA, NFP, and PAT who receive information about their child's learning and development from a standardized screening tool (ASQ 3) by the 6 month assessment	# of mothers enrolled in HFA, NFP, and PAT whose children are screened with the ASQ 3) by the 6 month assessment	Increase the number of mothers receiving information about their child's learning and development from a standardized screening tool (ASQ 3) by the 6 assessment	ASQ 3 results discussed with parents as documented in Client file	Process measure of % of mothers who receive information about their child's learning and development by 6 months. Comparison will be between cohorts.	Home visitor and mother will discuss ASQ 3 screening results by the time the child is 6 months post partum

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(iii)Parenting behavior: Responsivity	Mothers	% of mothers enrolled in HFA, NFP, and PAT who increase on the HOME construct: Responsivity between the 6 and 18 months assessment	#of mothers enrolled in HFA, NFP, and PAT who increase their score on the HOME construct: Responsivity between the 6 and 18 months assessment	# of mothers enrolled in HFA, NFP, and PAT who complete both the 6 and 18 month assessment	Increase score on HOME constructs: Responsivity between 6 & 18 months assessment	Tested with HOME Client file	Outcome measure of % of mothers who maintain or increase score on the HOME from 6 months to 18 months. Comparison will be within cohorts.	Test will be given at 6 and 12 months. Scale scores calculated for individual scales in the measure. The Responsivity scale score will be calculated based on protocol of the measure developer. Score from the test at 6 months will be compared to score from the test given at 18 months.
(iv)Parent emotional well-being	Women	% of women enrolled in HFA, NFP, or PAT who are screened for maternal depression	# of women enrolled in HFA, NFP, or PAT who are screened for depression at infancy 1-4 weeks	# women enrolled in HFA, NFP, or PAT who are 4 weeks postpartum and enrolled prenatally	Increase % of women screened for maternal depression at infancy 1-4 weeks	Screening with Edinburgh Postnatal Depression Scale (Client file)	Process measure of women screened for depression. Comparison between Cohort 1 and Cohort 2.	
(v)Child's communication, language & emergent literacy	Children	% of children enrolled in HFA, NFP, or PAT who are screened for communication delay by 6 months of age with the ASQ-3	# of children enrolled in HFA, NFP, or PAT who are screened for communication delay by 6 months of age with the ASQ-3	# of children enrolled in HFA, NFP, or PAT who are 6 months of age	Increase or maintain % of children screened for communication delay by 6 months of age	Ages and Stages Questionnaire (ASQ-3) collected through parent report &/or home visitor). Client file.	Process measure for percentage of children screened for communication delay with ASQ-3 by 6 months of age. Comparison will be between cohort 1 and cohort 2. Using the communication scale score.	

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(vi) Child's general cognitive skills	Children	% of children enrolled in HFA, NFP, or PAT who are screened for problem solving delays by 6 months of age with the ASQ-3	# of children enrolled in HFA, NFP, or PAT who are screened for problem solving delays by 6 months of age with the ASQ-3	# of children enrolled in HFA, NFP, or PAT who are 6 months of age	Increase or maintain % of children screened for problem solving delays by 6 months of age	Ages and Stages Questionnaire (ASQ-3) collected through parent report &/or home visitor). Client file.	Process measure for rate of children screened for problem solving delays with ASQ-3 by 6 months of age. Comparison will be between cohort 1 and cohort 2. Using the problem solving scale score.	
(vii)Child's positive approaches to learning including attention	Children	% of children enrolled in HFA, NFP, or PAT who are screened for learning delays by 6 months of age with the ASQ-SE	# of children enrolled in HFA, NFP, or PAT who are screened for learning delays by 6 months of age	# of children enrolled in HFA, NFP, or PAT who are 6 months of age	Increase or maintain % of children screened for learning delays by 6 months of age	Ages and Stages Questionnaire – Social Emotional (ASQ-SE) collected through parent report &/or home visitor observation. Client file.	Process measure for rate of children screened for learning delays with the ASQ-SE by 6 months of age. Comparison will be between cohort 1 and cohort 2.	Provides empirically derived cut-off scores for emotional competence. Designed to be used in conjunction with other developmental screening tool (ASQ3)
(viii)Child's social behavior, emotion regulation & emotional well-being	Children	% of children enrolled in HFA, NFP, or PAT who are screened for emotional well-being by 6 months of age with the ASQ-SE	# of children enrolled in HFA, NFP, or PAT who are screened for emotional well-being by 6 months of age	# of children enrolled in HFA, NFP, or PAT who are 6 months of age	Increase or maintain % of children screened for emotional well-being delays by 6 months of age	Ages and Stages Questionnaire – Social Emotional (ASQ-SE) collected through parent report &/or home visitor observation). Client File	Process measure for rate of children screened for emotional well-being with the ASQ-SE by 6 months of age. Comparison will be between cohort 1 and cohort 2.	Provides empirically derived cut-off scores for emotional competence. Designed to be used in conjunction with other developmental screening tool (ASQ3)

Construct	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(ix)Child's physical health & development	Children	% of children enrolled in HFA, NFP, or PAT who are screened for physical health and developmental delays by 6 months of age with the ASQ -3	# of children enrolled in HFA, NFP, or PAT who are screened for physical health and developmental delays by 6 months of age	# of children enrolled in HFA, NFP, or PAT who are 6 months of age	Increase or maintain % of children screened for physical health and developmental delays by 6 months of age	Ages and Stages Questionnaire (ASQ-3) collected through parent report &/or home visitor observation). Client File	Process measure for rate of children screened for physical health and developmental delays with the ASQ-3 by 6 months of age. Comparison will be between cohort 1 and cohort 2.	Separate reporting of both motor skill scores.

Benchmark 4: Domestic Violence*

Constructs	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
Domestic Violence **(i)Screening for domestic violence**	Mothers	% of mothers screened for experience of domestic violence during intake	# screened for DV completed at intake	# enrolled in HFA, NFP, and PAT	Increase % of program participants screened for domestic violence at intake	Interview (home visit record)	Process measure to be reported based on intake screening. Comparison will be between Cohort 1 and Cohort 2.	Each program uses a different screening tool. NFP: Maternal self report of experience of IPV during pregnancy & after delivery. PAT: Life Skills Progression. HFA: Kempe assessment. Interview. Dates screen is competed will be recorded in the home visits record.
Domestic Violence: **(ii)Referrals for domestic violence services for families with identified need**	Mothers	% of mothers referred to relevant domestic violence services based on % of mothers screened positive for domestic violence	# of mothers referred to relevant domestic violence services at intake or within 3 months of intake who screened positive for DV	# screened positive for DV at intake and remain in the program at least 3 months	Increase % of referrals made to domestic violence services at intake or within 3 months of intake	Interview (home visit record)	Process measure to determine the # of referrals made to mothers with domestic violence issues at intake or within 3 months of intake. Comparison will be between Cohort 1 and Cohort 2.	Intake is defined as the time it takes to do the initial screens and paperwork and may take more than one visit.
Domestic Violence **(iii)Safety plan completed for families with identified need**	Mothers	% of mothers for which a safety plan was completed within 3 months of intake based on % of mothers screened positive for domestic violence	# of mothers who screened positive for DV for which a safety plan was completed within 3 months of intake	# screened positive for DV at intake and remain in the program at least 3 months	Increase % of personal safety plans competed at intake and within 3 months of intake	Interview (home visit record)	Process measure documenting the number of safety plans created for mothers with domestic violence issues. Plans must be completed within three months of intake Comparison will be between Cohort 1 and Cohort 2.	DV is a sensitive subject. .It may take a few visits for the family to warm up to the home visitor. IPV is an important topic to discuss with the family as soon as possible. That is why a 3 mo. time frame is given for the visitor to complete a screen, give a referral and create a safety plan.

Benchmark 5: Family Economic Self-Sufficiency*

Constructs	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(i)Household income & benefits	Adults in household enrolled in the home visiting program	Household earnings from employment for all those enrolled in the home visiting program.	n/a	n/a	Increase or maintain total household earnings from employment	Interview (home visit record) See attached questions.	Measure of change in total monthly earnings from employment from enrollment to 1 year follow-up. Comparison will be within cohort.	Earnings are defined as income from employment. Definition of house hold is person(s) enrolled in the home visiting program funded by MIECHV
(ii)Education of adult members of the household	Adults enrolled in the home visiting program with an educational goal	% of household members completing educational goal.	# of household members completing educational goal.	# of household members with an educational goal.	Increase % of adult household members completing an educational goal between intake and 1 year follow-up	Interview (home visit record) SLVHD (NFP) to use checklist with date in client file See attached questions.	Outcome measure of change in household members completing educational goal between intake and 1 year follow-up. Comparison will be within cohort.	The definition of an educational goal will be determined by the adults enrolled in the program and will focus on earning credits toward a GED, high school completion, or other training / certification programs.
(iii) Health insurance status	Household members enrolled in the home visiting program.	% of household members who have health insurance from intake to one year post-partum.	# of household members who have medical/health insurance coverage at one year post-partum follow up that did not at enrollment	# of household members who did not have medical/health insurance coverage at enrollment	Increase in the % of household members who have health insurance from intake to one year post-partum	Interview (home visit record)	Outcome measure to increase % of household members who have medical/health insurance coverage at one year post-partum That did not have coverage at enrollment Comparison will be within cohort.	Focus on household members enrolled in the program.

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports

Constructs	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(i) Number of families identified for necessary services	Mothers	% of mothers screened for necessary services between intake and 6 month post partum	# of mothers screened for necessary services between intake and 6 months post partum	# of mothers enrolled in HFA, NFP, and PAT that are 6 months post partum	Increase or maintain % of mothers screened for identified needs	Interview (home visit record)	Process measure of number of mothers screened for identified needs. Comparison will be between Cohort 1 and Cohort 2.	Reporting will be based on period between intake and 6 months post partum
(ii)Number of families that require services & received a referral to available community resources	Mothers	% of mothers that were identified as needing services & received a referral to available community resources at intake	# of mothers that were identified as needing services and received a referral to available community resources	# of mothers enrolled in HFA, NFP, and PAT that were identified as needing services and are 6 months post partum	Increase or maintain % of referrals made for participating mothers.	Interview (home visit record)	Process measure of referrals provided for mothers with identified needs. Comparison will be between Cohort 1 and Cohort 2.	Reporting will be based on period between intake and 6 months post partum.
(iii) MOUs or other formal agreements with other social service agencies in the community	Partner organizations in community	# of MOU's at program initiation and at one year follow up	n/a	n/a	Increase # of social service agencies with MOU's	Implementing agency records / MOU's from agencies to whom program referrals are made. (Administrative data).	Process measure of total number of social service agencies with formal MOU. Comparison will be within group (individual implementing site or agency).	Reporting will be based on program initiation and at one year follow up.
(iv)Information sharing	Partner organizations in community	# of agencies with which the HV program has a clear point of contact with in the community program initiation and one year follow up	n/a	n/a	Increase # of agencies with which the HV provider has a clear point of contact in the community	Implementing agency records/ number of service agencies with which they communicate regularly. (Administrative data).	Process measure of total number of social service agencies with clear point of contact and includes regular sharing of information between agencies. Comparison will be within group (individual implementing site or agency).	Reporting will be based on program initiation and one year follow up. This will be defined as agencies with whom they communicate regularly (multiple times per year, not monthly) but operate without a formal MOU

Constructs	Population Group	Indicator	Numerator	Denominator	Quantifiable Improvement Measure	Data Source	Data format	Notes/ Justification
(v) Number of completed referrals	Mothers	% of completed referrals for which there are confirmed receipt of services	# of completed referrals where receipt of services is confirmed	# of referrals made between enrollment and 6 months postpartum	Increase or maintain % of completed referrals of participating mothers with identified needs whose receipt of service was verified	Interview (home visit record)	Process measure of % of completed referrals of participating mothers with identified needs whose receipt of service was verified. Comparison will be between Cohort 1 and Cohort 2.	Reporting will be based on period between intake and 6 months post partum.

Data Collection Instruments

For maternal depression Utah will use the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a 10-question instrument designed by J. L. Cox, J.M. Holden, and R. Sagovsky for measuring post partum depression nearly 25 years ago. It has been widely accepted and tested among diverse population groups. For other constructs such as substance abuse (tobacco in Utah), the three models will use other questions (included in administrative / screening records) that assess the use of tobacco. Although not a formal assessment measure these questions have been standardized and ask about use in lifetime and last 30-days (defined as current use).

For reductions in emergency department visits and child injury prevention data will be collected through participant self report / administrative records until OHV database has capacity to link with other Utah DOH / other hospital-related data systems to verify data accuracy. Child abuse, neglect and maltreatment data will be collected through administrative data provided by the Department of Child and Family Services (State CPS agency). The Utah Department of Health, Office of Home Visiting has had a number of discussions with DCFS and is currently in the process of finalizing a data sharing agreement with that agency. Data for this benchmark will be collected from a variety of sources including observation, direct assessment, administrative data, and parent-report.

The Ages & Stages Questionnaires (ASQ) is a parent-report questionnaire developed by Jane Squires, Diane Bricker, and Elizabeth Twombly. This standardized survey assesses child development during the first five years of life through 30 developmental items. The questionnaires focus on assessment of five key developmental areas: (1) communication, (2) gross motor, (3) fine motor, (4) personal-social, and (5) problem solving. Items in the problem-solving domain assess attention, memory, reasoning, academic skills, and perception. Each questionnaire takes 10 to 15 minutes to complete. The ASQ has demonstrated reliability, validity, and accuracy in discriminating children with and without developmental delays.

The validity of Ages & Stages Questionnaires, Third Edition (ASQ-3) has been evaluated extensively. The concurrent validity ranged from 74% for the 42-month ASQ-3 questionnaire to 100% for the 2-month and 54-month questionnaires, with 86% overall agreement. The sensitivity of ASQ-3, or the ability of ASQ-3 to correctly identify those children with delays, ranged from 75% for the 6-month questionnaire to 100% for the 4-month, 14-month, 54-month, and 60-month questionnaires, with 86% overall agreement. The ability of ASQ-3 to correctly identify typically developing children, ranged from 70% for the 14-month questionnaire to 100% for the 2-month, 16-month, and 54-month questionnaires, with 85% overall agreement.

We propose to implement the ASQ: SE as the preferred social emotional screening tool. This tool, part of the Ages & Stages family of related instruments, is used by the local EBHV programs and is ideal for identifying infants and young children whose social and

emotional development requires further evaluation to determine if referral for intervention services is necessary. The ASQ: SE has been widely studied with validity, reliability, and utility studies were conducted between 1996 and 2001. Psychometric studies based on normative samples of more than 3,000 questionnaires for ASQ: SE show high reliability (> 90%), internal consistency, sensitivity, and specificity (Squires et al., 2001). Each questionnaire takes approximately 20 minutes to complete.

We also intend to use the HOME to collect other required benchmark data. HOME, an acronym for **H**ome **O**bservation for **M**easurement of the **E**nvironment (Caldwell & Bradley, 1984), is designed to measure the quality of stimulation and support available to a child in the home environment. The Infant/Toddler (IT) HOME is designed for use during infancy (birth to age 3). It is composed of 45 items clustered into 6 subscales: 1) Parental Responsivity, 2) Acceptance of Child, 3) Organization of the Environment, 4) Learning Materials, 5) Parental Involvement, and 6) Variety in Experience. Administration requires approximately one hour in a low-key semi-structured observation and interview done to minimize intrusiveness and allow family members to act normally. The instrument has been used in more than 500 studies and has strong psychometrically valid features.

Reliability / Validity of Measures

Fortunately, all of the proposed measures have been used by the evidence-based program models for several years, with the exception of the HOME. All of these measurement tools have well-documented reliability and validity for use with the target population, and are readily available in Spanish (an important consideration in Utah with the growing number of non-English clients).

The administrative data from the evidence-based model programs is gathered through home visits and recorded as part of standard case files for each client family. The Office of Home Visiting has met with each implementing site several times to train supervisors and home visitors in benchmark data collection process, including the use of specific questions to ensure uniformity in data collection. In addition to the individual site meetings, the Office of Home Visiting has provided professional development training to supervisors and home visitors in the use of the ASQ-3, ASQ SE, and the HOME.

Data Quality

One of the major strengths offered by the Nurse Family Partnership is its data collection and monitoring system. Much of the data collected that supports NFP's position as an evidence-based home visiting program was collected through its Clinical Information System, which has been rolled into a customized version of Social Solutions' Evidence to Outcomes (ETO) system. NFP expends considerable resources on the data monitoring function of its database.

The OHV has both a data sharing agreement in place with NFP's National Service Office as well as an approved RAPComm (NFP's research approval process) that was established in

2010 as part of ACF's previously awarded "Evidence-Based Home Visiting" grant. Also the OHV will be able to access NFP data directly via a new Nurse-Family Partnership State Service and Support Agreement that is being approved jointly by the Utah Department of Health and NFP's National Service Office. This will provide direct access to benchmark-related data via an online module "ETO-Direct" which OHV staff will be able to use.

The NFP data collection procedure is strength of the program. The way the system works is that the Nurse Home Visitors (NHV) conducts home visit interviews, and observations, which allows them to gather self-reporting and self-administered surveys / scales from the clients. These data are then entered directly into the national NFP web-based information system by data entry personnel, nurses and supervisors. To ensure quality, the local nurse supervisor meets weekly with staff and monitors data entry for access. Additional monitoring is also conducted by the NSO. Training on the reporting system is provided to local staff via online modules, manuals, webinars and direct education. Technical assistance is continuously available through the NSO, which has an office specifically focused on "Information Technology and Program Quality". Additionally, NFP infrastructure offers Nurse Consultants and Regional Quality Coordinators to review data and reports on a regular basis to ensure quality and to identify areas for improvement.

The OHV database has grown and improved significantly in recent months and it is estimated that complete benchmark data entry, monitoring, and reporting capability will be operational as of May 1, 2012. This expansion will allow both HFA (who has been using the database for more than 2 years) and PAT to enter data for MIECHV-required benchmark constructs directly into the database. The database provides a series of internal checks and balances to support accurate data entry by the implementing sites in Utah. Direct monitoring by OHV staff on a monthly basis is ongoing to ensure timely and accurate data entry. Another active process that is ongoing is data entry training, which is also provided by the OHV staff. Training is viewed as a critical process to support data entry accuracy and quality.

Until the modifications to the OHV database are complete, to align all data elements with the MIECHV benchmarks the HFA and PAT programs will use a standard intake packet created by the OHV that will help ensure complete data collection for clients. Additionally, the PAT programs will continue to use Visit Tracker to collect their data. This online program also includes a number of features that support accurate data entry, thus contributing to the maintenance of a quality data system.

Data Protection

Data collection and reporting protocols used by HFA, NFP, and PAT have been developed to assure privacy and confidentiality. NFP's online database uses 128-bit security encryption, the industry standard for these technologies. Further, data transmissions are also encrypted using Secure Socket Layer (SSL) communications. Similarly, both Visit Tracker and the Utah's home grown OHV database uses security enabled software and each home visitor has a unique ID login and password.

Another element that supports our efforts to protect the data is staff training and data management. Each of the implementing agencies has their own policies and procedures outlining the requirements to protect client data. Staff at each of the sites is trained in these protocols annually and reminders are provided by program managers in staff meetings and during direct supervision meetings. From the perspective of the state, additional protections are in place. In order to collect data the OHV had to obtain a Utah Department of Health Institutional Review Board (IRB) approval. This is a formal review requiring written protocols and assurances that both paper copies and electronic data would be secure. Maintaining compliance with HIPAA requirements was also a required feature of these applications. As a part of the data collection, client consent procedures were included that require specific staff training as well.

Data Analysis Approach

For benchmark purposes we have defined Cohort 1 to consist of all families enrolled during the first operational year (Benchmark approval to one year later) and Cohort 2 will be all families enrolled during the second operational year(beginning one year and one day after benchmark approval). While the Office of Home visiting had an existing online database for use by implementing agencies, a number of additional changes were necessary to facilitate the collection of all of the benchmark constructs detailed in this document. During the interim, while the database is being modified to accommodate all benchmark tracking requirements, a standard set of data collection forms will be used to ensure the collection of the required data elements. We anticipate this will be completed in the spring of 2012, at which time these data elements will be entered into the OHV database.

Qualifications of Key Staff

Staffs from the University of Utah Social Research Institute and Utah State University Early Intervention Research Institute are taking the lead on data collection and the evaluation of the project in Utah. The lead evaluator will be Rodney Hopkins from the University of Utah and he is responsible for planning, evaluation and overall data collection. He has been involved in program evaluation activities focusing on public health and education for the past 20 years. He is being assisted by Mark Innocenti from Utah State University who has been involved in a variety of large studies including projects focusing on Head Start. He will primarily be responsible for data analysis and has nearly 30 years of senior research experience.

Angela Ward is the Program Specialist. Angela was formerly the HFA supervisor for the Davis Family Connection Center and has extensive hands-on experience in home visiting. In her new capacity, Angela is involved in monitoring program implementation including database usage. She facilitates all professional development training and provides technical assistance support to the implementing agencies.

Challenges and Potential Barriers

The challenges anticipated related to benchmark reporting in Utah have to do with the small number of program participants in the evidence-based home visiting programs. Since Utah only has 4 existing (1 NFP & 3 HFA) implementation sites there are currently less than 200 participants. Although the MIECHV funding will allow some expansion, the lack of local funding support for the programs is problematic and will prevent any significant growth, unless the economy changes.

A second perceived data collection challenge will be to gain client permission to conduct an administrative data check of their protected information against CPS child maltreatment records. We anticipate some families will not sign a release of information. To address this, our protocol is to approach each family after 6 months of enrollment in the program. This will allow the home visitors to establish a close relationship based on trust. Then the home visitor will approach the family with the consent to release their information. In discussing this with implementing agencies, this was the preferred method, rather than trying to obtain the release during the initial enrollment period along with other consents.

Questions to be used in Utah to collect construct and benchmark data.

Benchmark 1
i) Do you have a medical provider? Y N. If no follow up with referral and record date mom obtained a medical provider.
ii) Do you smoke? Y N.
iii) Did you receive a health care visit in the past 6 months?
vi) Did you breastfeed your baby? How long did you breastfeed your child? (Any combination of breastfeeding and formula supplementation)
vii) In the past 6 months has your baby received a health care check-up? Y N. If yes, _____ (approximate date).
viii) Is your baby covered by some type of health insurance? Y N.
Are you (mother) covered by some type of health Insurance? Y N.

Benchmark 2
i) How many times did your child visit the emergency room/department/ or urgent care center during the last 6 months? (Do not count visits where your child was not the one being treated). _____ (number recorded)
ii) How many times did you visit the emergency room/department/ or urgent care center during the last 6 months? (Do not count visits where you were not the one being treated).
iii) How many times did your child have injuries requiring medical treatment (ambulatory care, emergency department / or urgent care center visits, or hospitalizations) during the last 6 months?

Benchmark 5
i) What is your combined household earnings for everyone enrolled in the program? Earnings are defined as income from your job on average per month. (record amount _____). To be gathered at enrollment and 12 months post-enrollment.

ii) Do you currently have an educational goal you are pursuing? Y N
If yes, what is it? (i.e. GED attainment, high school completion, or other training / certification program)

1 Year Follow-up Question: Did you complete your educational goal? Y N(ii)What is the health insurance status for each person enrolled in the home visiting program?

_____ (record whether they have insurance or not)

Section 6: State Administration of the State Home Visiting Program

Overall Management Plan at the State and Local levels

Management of Utah's MIECHVP will be carried out by the Utah DOH (UDOH), Division of Family Health and Preparedness (DFHP), Bureau of Child Development, and the Office of Home Visiting (OHV). UDOH has successfully administered the MCH Block Grant since its inception. The OHV has been administering the ACF/EBHV (Supporting Evidence-based Home Visiting Programs to Prevent Child Maltreatment) grant for the last three years. The EBHV grant and the MIECHV program are administered by the OHV Program Coordinator which ensures that both projects are well coordinated. The OHV 6views the MIECHV funding opportunity as an avenue for continuing the work that Utah has been doing to develop a statewide home visiting program.

Day-to-day administration of Utah's MIECHV home visiting program will be done by the OHV Program Coordinator, who also has administrative responsibilities for Utah's EBHV program. The OHV will assume the role of funding agent for local home visiting programs as well as a program monitoring role. The Program Coordinator will develop the criteria for sub-contracts in accordance and compliance with the MIECHVP federal guidance and state requirements. The renewal of contracts will be dependent on funding, reporting requirements, and program performance that indicates adherence to fidelity standards. Additionally, the Program Coordinator is responsible for developing an overarching budget; overseeing the work of OHV staff including the internal and external evaluators (contracted staff); and strengthening a statewide home visiting system. The OHV Program Coordinator reports to the Program Manager of Part C Early Intervention who reports to the Director of the Bureau of Child Development. The Title V director is also the Deputy Director of the Division of Family and Health Preparedness. The Program Specialist reports to the Program Coordinator and is responsible for providing technical assistance to implementing agencies and coordinates and manages the development of the state home visiting database.

The OHV coordinator will work closely with the model developers to ensure programs are implemented according to implementation plans and as prescribed by the respective model, maintain fidelity to the respective model, and comply with all requirements of the MIECHVP. Important to the success of the state home visiting plan is the OHV's location within the BCD along with Child Care Licensing, Head Start State Collaboration Office, the State ECCS grant coordinator and IDEA Part C Early Intervention Program.

At the local level, individual programs will manage the delivery of evidence-based home visiting services and will continue to be supported and monitored by the national model developers,

the state office of PAT, and the OHV, from which they will receive model-specific training and technical assistance for effective implementation, program delivery and continuous quality improvement. Data quality will be monitored by the OHV or the national program model. The challenges of collecting, transferring and aggregating data for meaningful analysis and reporting are being addressed by the OHV evaluation staff. Section Four provides a more detailed description of implementation oversight and monitoring by the OHV staff.

Additional Collaborative Partners

The OHV has been involved in state level infrastructure development since the award of the EBHV grant. Early on in this process, the OHV recognized the need to form several committees to bring additional resources together to support the work. The OHV Advisory Committee was created with membership that consisted of personnel from all the local EBHV programs as well as state and local partners such as UDOH program staff, Intermountain Healthcare, Division of Child and Family Service, Voices for Utah Children, Division of Substance Abuse and Mental Health, to name a few. The role of this committee was to support the OHV in the roll out of the EBHV implementation plan. In 2010, the OHV Steering Committee was developed to assist with the development of the HRSA required needs assessment plan and the current updated plan.

A full list of collaborative partners can be found in Section 1 of this application.

Plan for Coordination of Referrals, Assessment, and Intake Across Models

As part of the application and RFP process, applying programs were asked to provide a plan for coordination of referrals, assessments and intake processes. The OHV is working with local communities, through local early childhood councils and/or home visiting coalitions, to develop triage mechanisms to promote coordination of referrals and assessments, as well as with other early childhood services that best fit their communities. The OHV will provide ongoing support and technical assistance. Section 4 provides a description of what targeted communities are doing to improve coordination of referrals and intake and the role the OHV has in this process.

Evaluation Efforts

As an EBHV grantee, the OHV is participating in a federal cross-site home visiting evaluation as well a local evaluation. The OHV contracts with the University of Utah, Social Research Institute and Utah State University, Early Intervention Research Institute to design the evaluation plan. The evaluators will assess programs' progress towards achieving required benchmarks.

Meeting Legislative Requirements

Staff Training and High Quality Supervision

As part of the application and RFP processes, applicants were asked to describe their plans for recruiting, training, and retaining qualified staff. Each of the evidence-based home visiting models being implemented in Utah has essential requirements or core elements related to the training, ongoing professional development and competence of staff and the quality of staff supervision. All programs under consideration for the MIECHVP funding will be required, as part of their contract, to hire staff based on the requirements of the program model they are implementing. NFP, HFA and PAT all require reflective supervision. The OHV will monitor programs through contract compliance activities described earlier in this plan and programs will receive additional monitoring

through the national model developers. Details regarding model specific training and supervision are provided in the table and narrative in Section Four.

The OHV will reconvene its ad hoc professional development work group whose focus is establishing a cross agency professional development system to support home visiting programs and other early childhood professionals. The OHV, through the professional development work group, will explore ways to encourage the use of coaching as a strategy for improving staff practice.

At the state level, all OHV employees will be hired according to policies and procedures established by the Department of Human Resources Management. The previous MIECHV plan, as well as this one, Program Coordinators will have experience working in a public health or social service environment, ideally administering a public health or social service program, program planning, budget development and resource allocation, and have a minimum of a bachelor's degree in public health, early childhood development, social work, or a related field. Program Specialists will have experience working in a public health or social service program, preferably in a home visiting program and have a minimum of a bachelor's degree in a social service or related field.

Organizational Capacity

The organizational capacity of the UDOH to implement and administer the home visiting program is demonstrated through its history serving at the state's Title V agency and its management of Utah's MCH block grant. The OHV is the grantee of the Administration for Children and Families, *Supporting Evidence-based Home Visiting to Prevent Child Maltreatment* and has been administering that grant since 2008. As mentioned previously, the OHV is located within the Bureau of Child Development which houses several early childhood programs and provides the organization structure to foster collaboration.

As part of the RFP process, applicants were asked to describe their organizational capacity to support an evidence-based home visiting program.

Referral and service networks

As part of the RFP process applicants were asked to provide a plan for coordinating services in the community as well as to provide letters or MOUs that detail the role of agencies involved in the support and implementation of the home visiting program. Applicants were also asked to provide a plan for integrating the home visiting program into a network of early childhood service provision. The OHV will continue to support home visiting programs to build or strengthen collaborations with other organizations that serve pregnant women and families with young children. At the state level the OHV will provide leadership to ensure that home visiting is integrated into developing and existing systems. The work of the OHV is guided by its Steering Committee and shared responsibility for the development of Utah's state home visiting plan. The OHV Steering Committee acts as an advisory body to the OHV providing strategic decision making, assists interagency coordination and will provide leadership on policy development for the home visiting program. This committee will continue to support OHV and Utah's home visiting programs and new members will be added as needed. The Committee will meet monthly for the next year providing strong oversight to the MIECHV implementation activities. Committee membership is provided in Section 1.

Monitoring of fidelity of program implementation

The OHV will monitor fidelity, in coordination with the national model offices, of the implementing program it is funding. Each program model includes specific mechanisms for monitor the fidelity of the local implementing program. Through its contracts with local implementing agencies, the OHV will monitor the program activity to ensure that they comply with all model specific requirements in order to maintain fidelity. The OHV will offer technical assistance to support implementing agencies in maintaining fidelity to the model, and require corrective action plans if model fidelity is consistently violated. Section Four provides specific details on how the OHV will manage monitoring of the MIECHV funded programs.

Compliance with model-specific prerequisites

The OHV, in conjunction with the MIECHV funded programs, will work closely with model developers-and the Utah PAT state director- to assure that all prerequisites for implementation and maintenance of fidelity and quality are met. These relationships will be maintained through implementation to assure that the MIECHV program goals, objectives and activities are met in addition to model specific requirements. The OHV will monitor all processes and outcomes for contract compliance. The home visiting models being implemented in Utah require implementing organizations to develop a program plan that must be submitted for review and approval by the model developers.

Administrative Structure

The Office of Home Visiting was created with the first federal funding of home visiting in 2008 eliminating the need for change in the administrative structure to support the MIECHV program. A full-time program coordinator was already in place, as was a health program specialist and project evaluators. The Bureau for Children with Special Health Care Needs supports with home visiting program with a .25 support services specialist that provides financial support to the OHV. The OHV has an outstanding request to hire a .50 administrative assistant. The OHV Program Coordinator and direct supervisor will develop a plan for the hiring of a staff person over the next six months. The Title V Director and the BCD Director both provide significant support to the state MIECHV program; there is no budget impact associated with their efforts. See Attachment 3 for the organizational chart.

Collaborative Relationships

As part of the Bureau of Child Development, the OHV collaborates with the ECCS Coordinator, Child Care Licensing, Part C Early Intervention program, Head Start State Collaboration Director Early Childhood Developmental Screening Coordinator as well as with and Title V Director and the DCFS Community-based Child Abuse Prevention Program Administrator. Additional levels of collaboration have been discussed throughout this application and specifically in Section 4.

Organizational Chart: See Attachment: 3

Job descriptions for key positions: See Attachment 4

Section 7: Plan for Continuous Quality Improvement

Continuous Quality Improvement (CQI) is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance. CQI has the potential to:

- Provide a means for community-based programs to benchmark their processes and outcomes;
- Inform the adaptation of evidence-based home visiting models to the unique community settings in which they are implemented, taking advantage of local insights;
- Develop and incorporate new knowledge and practices in a data-driven manner;
- Inform programs about training and technical assistance needs;
- Help monitor fidelity of program implementation;
- Strengthen referral networks to support families;
- Provide rapid information on a small scale about how change occurs;
- Identify key components of effective interventions; and
- Empower home visitors and program administrators to seek information about their own practices.

Utah is committed to developing an effective CQI process that will result in high quality home visiting programs that meet identified benchmarks. The steps toward developing a strong CQI process include: a) building a data infrastructure, b) identifying people responsible for maintaining the CQI process, c) leveraging resources to support CQI activities, and d) developing a data system that supports and helps maintain the CQI process. All of these activities have already begun in Utah as part of our participation in the EBHV research process. This section will describe activities currently occurring and those planned as we move forward with the MIECHVP. In brief, the OHV intends to support CQI for each funded program by facilitating the creation of a state CQI team, developing a data "dashboard", collecting quarterly reports using an already developed (collaboratively with home visiting programs) management information system (MIS), and providing technical assistance as per CQI team recommendations and program requests.

Model-specific internal CQI elements

Evidence based programs have internal CQI elements specific to their models. Internal CQI elements include annual reports, affiliation and certification requirements, and self-assessment tools. Programs are responsible for obtaining and maintaining affiliation, performing self-assessments and reporting to their model developers. The program internal CQI efforts are described below. Each of these model CQI activities will occur in tandem with Utah CQI efforts.

NFP focuses its CQI efforts on improvements in program implementation and achieving maternal and child health and development outcomes. NFP uses its Clinical Information System (CIS) to monitor key implementation components and outcomes, which are compared to benchmarks achieved in its research trials. Data gathered through the NFP CIS are analyzed routinely to serve as a foundation for stimulating quality improvement within sites.

A key focus of CQI has been on assurance that NFP sites implement the program in accordance with 18 core model elements which increase the likelihood that the program will be delivered with fidelity to the model. Reports made available to sites by the national office enumerate the degree to which they meet, exceed or fall short of implementation benchmarks and maternal and child health outcomes.

HFA monitors CQI through its accreditation process. The accreditation process ensures the quality of each HFA affiliate through adherence to best practice standards. HFA is a comprehensive model that utilizes all program components for continuous quality improvement. Accreditation is necessary to maintain both affiliation with the HFA model and the right to use the HFA name.

Each HFA program develops its own Self Study which provides the program with an opportunity for internal review of its service delivery and administration against professionally accepted and research-based national standards. The self-study is the program's opportunity to demonstrate implementation of the standards and serves as both a process and a document. The 2-4 day site visit becomes the program's opportunity to learn if an objective peer review can validate its self-analysis. The analysis is based on 160 standards outlined in the HFA Self Assessment Tool.

PAT (PAT) offers a technical assistance plan for continuous quality improvement. Process evaluation examines what goes on inside a program while it is in progress, focusing on activities offered, staff practices, and actions of children and families. Affiliates report annual data on service delivery, program implementation and compliance with model replication requirements. Additional best practices support affiliates as they engage in continuous quality improvement by providing quality indicators that connect to even higher levels of excellence in serving families

Utah MIS infrastructure development
Utah has developed a MIS system for home visiting programs as part of our EBHV grant. The MIS system provides a program-friendly approach to providing information on implementation fidelity (e.g., families enrolled, number of home visits, length of home visits, etc.) as well as information on outcomes linked to benchmark areas (e.g., ASQ scores, AUDIT scores, etc.). This MIS system has been developed and implemented over the past 18 months. Creating crosswalks between model specific data reporting requirements and state benchmarks is an ongoing process. However, all currently funded HFA programs are using the MIS system to input information. The OHV is working with NFP and PAT to link program model MIS systems with the Utah MIS system. Technical assistance from the OHV has been provided and will continue as needed with already funded programs and with programs to be funded. Quarterly reporting systems useful to programs and to the OHV are being developed. This is a strong aspect of the Utah infrastructure that will be supported by the OHV and will be incorporated into CQI plans.

An advantage of having a Utah MIS system is that equivalent data will be available for all home visiting programs in the state. Quarterly reports will be required by the OHV visiting. The OHV is working toward a data based solution where the MIS will allow programs to request a report function that would produce needed data. It is anticipated that this function will not be available until 2012. Until then, OHV evaluation staff will work with programs on reporting requirements that will be submitted. All funded programs will be required to submit this report and contents will be

monitored by the OHV. OHV staff will combine all data elements from each program report into a master quarterly report. Individual program and combined quarterly reports will be available for Advisory Board review.

Requiring quarterly reports from MIECHVP grantees serves many purposes. The OHV can monitor fidelity through examination of quarterly reports. Quarterly reports will give the OHV an overall snapshot or status report of its grantees (enrollment numbers, affiliation status). A quarterly report also provides a way to assure that programs are capturing data for benchmarks throughout the year, hopefully easing the end of year federal reporting requirements. The quarterly reports are a direct way for the OHV to be sure grantees are completing required activities.

The CQI process will be strengths based and not punitive. Parallel process will be used to improve programs. Parallel process is guided by the statement "do unto others as you would have others do unto others" (Pawl & St. John, 1998). The underlying approach for CQI needs to mirror the process used by program supervisors with their staff (Heller & Gilkerson, 2009) if the goal is to develop a culture of quality. However, the CQI process will be informed by data that can be used in strengths based format. The responsibilities of the OHV-CQI team will include:

- Monitor program fidelity
- Review quarterly data
- Review model fidelity data
- Review dashboard measures
- Review/analyze data
- Share information with Advisory Committee

1. The CQI team will work with the Advisory Committee to develop a process for working with programs. An example process may include the following steps: Identify a need that will improve quality based on available data.
2. Break down issue into component parts; use data if available.
3. Analyze the problem - identify functional data that can be collected at the program level.
4. Develop a Quality Improvement Plan (QIP) – define specific actions to be taken; identify who, what, when and where; identify how you will know if issue is resolved.
5. Examine the results - identify if the target has been met and display results in graphic format before and after the change.
6. Start over - go back to the first step and use the same process for the next quality goal.

A CQI team will coordinate support for all local EBHV programs. This Team will support and oversee model specific and community level training and coaching to ensure quality implementation, adherence to fidelity, and the development CQI processes. The Team and the OHV will also provide Systems Level Development.

The CQI team will meet with each program three times per year and will work with the program staff to develop a Quality Improvement Plan (QIP). The QIP will be monitored on a regular basis and adjusted to meet the needs of the program. Regular monitoring of and progress toward established goals is important to establishing a culture of quality based on data. The QIP will be informed by the above information and by other sources of data that need to be available for the QIP. A summary of this process will be presented in a meaningful way to the Advisory Committee. The CQI team and the program QIP process will be an ongoing agenda item for the Advisory Committee.

Develop an MIS System that Supports and Maintains CQI

Given the described infrastructure activities the Advisory Board and the CQI team will have access to model specific CQI information and OHV quarterly report information. This provides good information but it is important to make the information usable for local program staff. Activities have begun to develop a “dashboard” of indicators for programs and initial efforts have been presented to the Advisory Board. This dashboard will include indicators related to implementation fidelity (e.g., % of scheduled visits completed, % of slots filled) and to benchmark indicators (e.g., % of children receiving well child visits, % of children immunized). Dashboard indicators will also include process outcomes that are related to benchmark outcomes. Regular collection of simply answered questions collected from both families and home visitors can provide information that demonstrates if intended goals are being achieved. The OHV evaluators, the Advisory Board and program staff need to participate in all discussions related to dashboard indicators. The goal is to have understandable and usable data. Dashboard indicators may be introduced over time which would allow the opportunity to determine if the information is useful to programs and the Advisory Board. It is clear that for the CQI process to be sustainable over time it must be meaningful to all involved.

Utah is committed to developing a meaningful and sustainable CQI process based on data that leads to achieving benchmarks. A strong data collection infrastructure has been established and will be continued. Strong progress toward implementing and monitoring evidence-based home visiting programs in Utah has occurred; these activities will continue and improve under the MIECHVP.

Section 8: Technical Assistance Needs

The OHV would like to receive technical assistance with:

- Developing a statewide early childhood system that incorporates home visiting;

- Developing a Continuous Quality Improvement Plan and bringing on board new communities;
- Communication and marketing of home visiting;
- Advocacy and funding efforts; and
- Developing a training system for home visiting program staff?

Section 9: Reporting Requirements

The OHV assures that Utah will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. The State assures that its report will address and provide a discussion of updates or revisions and obstacles and challenges in the following areas:

- State Home Visiting Program Goals and Objectives
- State Home Visiting Promising Program Update (if applicable)
- Implementation of Home Visiting Program in Targeted At-risk Communities
- Progress Toward Meeting Legislatively Mandated Benchmarks
- Home Visiting Program's CQI Efforts
- Administration of State Home Visiting Program